AMERICAN HEALTH LAW ASSOCIATION

HEALTH LAW CONNECTIONS
June 2021

Price Transparency 2.0

Herd Midkiff, JTaylor

The Hospital Price Transparency Final Rule (Price Transparency Rule) went into effect on January 1, 2021,[1] putting an end to years of industry pushback and legal challenges to the requirement that hospitals publish their payer-specific negotiated rates in a consumer-friendly manner. Price transparency has been discussed at the federal level as far back as 2006, when President George W. Bush urged hospital industry leaders to make their prices for health care more transparent and understandable by consumers.[2] That original push gained little traction, but when the Affordable Care Act (ACA) was passed during the Obama administration in 2010, it contained a provision that required "each hospital operating within the United States" to "make public (in accordance with guidelines developed by the Secretary) a list of the hospital's *standard charges* for items and services provided by the hospital."[3]

In the Fiscal Year (FY) 2015 Inpatient Prospective Payment System Final Rule,[4] the Centers for Medicare & Medicaid Services (CMS) provided guidelines for implementing this ACA provision after the requirement had largely been ignored since the law's passage. In this rule, CMS required hospitals "to make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice), or

their policies for allowing the public to view a list of those charges in response to an inquiry."[5] However, it was not until 2018 that CMS provided further guidance requiring standard charges to be posted in a machine-readable format and updated at least once a year.[6]

Hospitals began complying with this requirement by publishing long lists of their "standard charges," which was a term that the regulation did not define. Hospitals published charge information based upon the industry accepted definition of "charge," which is the rate reflected on the hospital's chargemaster.[7] The amounts contained on the chargemaster, however, are not reflective of the actual price paid for services rendered to patients covered by government or commercial payers.

Government payers such as Medicare and Medicaid pay for services based on federal or state-mandated payment formulas derived from hospital costs, and commercial payers individually negotiate reimbursement rates for hospital services provided to their members. The resultant government and commercial payment rates can range from 20% to 80% less than the stated hospital charge.

Since the goal was to provide consumers, i.e., patients, with price information to assist with care decisions by allowing them to estimate out-of-pocket costs, CMS believed disclosing charges was not an adequate solution. Acting on a 2019 executive order issued by President Trump,[8] CMS finalized the Price Transparency Rule in which the term "standard charge" was defined and enhanced to include the rates negotiated between hospitals and commercial payers. This new rule was vigorously opposed by hospitals, but by the end of 2020, the U.S. District Court for the District of Columbia upheld the rule and all appeals were exhausted.[9] The rule stood and "Price Transparency 2.0" (as we have deemed it) became a requirement for more than 6,000 hospitals across the United States.

The primary goal of the Price Transparency Rule is to reduce health care costs by fostering competition through increased consumer price awareness. While the rule went into effect on January 1, 2021, the industry is seeing varying levels of compliance as each hospital determines how to implement the pricing disclosure requirements.

Rule Requirements

The Price Transparency Rule contains three main sections. The first section defines and enhances the term "standard charges." The second section provides details on how hospitals are required to disclose this information. And the third section contains the penalties for noncompliance.

Standard Charge Definitions

As noted previously, the ACA did not define the term "standard charge" and, accordingly, hospitals used the industry accepted definition of "charge." The new rule, however, provides five definitions of standard charge that are included in the transparency disclosure requirement.[10]

1. Gross Charge

The *gross charge* is the charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts. This is the "charge" amount as typically understood in the industry.

2. Discounted Cash Price

The *discounted cash price* is the discounted charge amount that applies to a patient who pays cash or a cash equivalent for a hospital item or service. Many hospitals offer a standard discount from their chargemaster rates for patients who are uninsured and therefore paying for hospital services 100% out-of-pocket.

3. Payer-Specific Negotiated Charge

The payer-specific *negotiated charge* is the charge (i.e., reimbursement amount) that a hospital has negotiated with a third-party payer for an item or service. This is the "contracted rate" or the "allowed amount" between the hospital and a particular commercial payer.

4. De-Identified Minimum Negotiated Charge

The *de-identified minimum negotiated charge* is the lowest charge (i.e., reimbursement amount) that a hospital has negotiated among all third-party payers for a particular item or service. This is the lowest contracted amount for an item or service.

5. De-Identified Maximum Negotiated Charge

The *de-identified maximum negotiated charge* is the highest charge (i.e., reimbursement amount) that a hospital has negotiated among all third-party payers for a particular item or service. This is the highest contracted amount for an item or service.

Hospital Posting Requirements

The Price Transparency Rule requires that hospitals make public the following:[11]

- A **machine-readable file** containing a list of all standard charges (as defined above) for all items, services, and service packages that could be provided by a hospital to a patient in connection with a hospital inpatient admission or outpatient visit.
- A **consumer-friendly** list of standard charges for 300 "shoppable"[12] services as defined by CMS and individual hospitals.

Both items must be accessible via a hospital's website with no requirements for patients or members of the public to provide credentials or any personal information to access the data. CMS has allowed a "co-insurance" estimator tool accessible via a hospital's website to satisfy the requirement to post the consumer-friendly list of shoppable services.

Penalties

To enforce compliance with these disclosure requirements, CMS will impose penalties on hospitals that fail to follow the Price Transparency Rule. If a hospital fails to comply with the rule, CMS is authorized to take the following actions:

- Provide a written notice to the hospital of the specific violation(s);
- Request a Corrective Action Plan (CAP) from the hospital if its noncompliance constitutes a material violation; and/or
- Impose a Civil Monetary Penalty on the hospital and publicize the penalty on a CMS website if the hospital fails to respond to CMS' request to submit a CAP or comply with the requirements of a CAP.

CMS is authorized to impose a monetary penalty for noncompliance of up to $300 per day, per hospital.[13] Based on this maximum daily amount, an individual hospital that is out of compliance for a full year could face a monetary penalty of almost $110,000.

In addition, the FY 2021 Inpatient Prospective Payment System Final Rule (FY 2021 IPPS Final Rule) requires hospitals to report median payer-specific negotiated charges (i.e., payer-specific negotiated rates) for Medicare Advantage organizations on their Medicare cost report for reporting periods ending on or after January 1, 2021.[14] The payer-specific negotiated charges used by hospitals to calculate these amounts are the same payer-specific negotiated charges for service packages hospitals are required to make public under the Price Transparency Rule. This data will be used in a new methodology for calculating Medicare Severity Diagnosis Related Groups relative weights for inpatient hospital stays beginning in FY 2024.[15]

In what has been described as a "poison pill"[16] to hospitals that may opt to pay the penalty described above rather than comply with the Price Transparency Rule, the failure to report the required payer-specific negotiated charges on a hospital's cost report may result in a hospital being denied all Medicare payments.[17] While this is not a direct penalty under the Price Transparency Rule, this cost reporting requirement under the FY 2021 IPPS Final Rule certainly signals CMS' intention to use data developed by hospitals as a result of the Price Transparency Rule, and to use various policy tools to incentivize hospital compliance with the rule.

CMS Goal of Price Transparency

CMS has stated explicitly that its primary goal with price transparency is to provide information to the market that, over time, will help control health care costs. CMS notes that health care spending is projected to consume 20% of the U.S. economy by 2027, and that "one reason for this upward spending trajectory is the lack of transparency in healthcare pricing."[18] The Price Transparency Rule cites numerous studies by health economists and other experts supporting the assertion that "there is a direct connection between transparency in hospital standard charge information and having more affordable healthcare and lower healthcare coverage costs."[19]

The theory behind price transparency rests on traditional market economic theory, where well-informed buyers and sellers lead to increased efficiency and lower costs through choice and competition. CMS also provides examples of price transparency initiatives imposed by certain states, including those in California, Massachusetts, Oregon, Colorado, and New Hampshire, as further support for the federal Price Transparency Rule.[20] While each of the various state initiatives has different requirements, they all share similar goals in making charge and price information available to the public so they can make more informed health care decisions and provider choices. Specifically, research regarding New Hampshire's price transparency efforts indicates that providing insured patients with pricing information can reduce out-of-pocket costs for some types of health care services by enabling them to choose lower-cost options. The studies showed that *all* patients benefitted from lower prices, even those who did not use the New Hampshire price transparency website, presumably due to competitive forces resulting from the publicly available pricing information.[21]

Impact of Price Transparency

The Price Transparency Rule's posting requirements and the expanded definition of "standard charge" greatly enhance the pricing disclosures hospitals must make to patients and consumers. Industry participants argued in comments to CMS and in court that CMS had exceeded its legal authority in promulgating the rule, that complying with the rule would be unduly burdensome, and that the rule forces hospitals to disclose confidential information.[22] Ultimately, the courts sided with CMS and the Price Transparency Rule stood as published. It remains to be seen whether the goal of reducing costs through transparency will be achieved, and it will take time before the rule's ultimate impact is understood. However, there are several known barriers that present headwinds to the promises of benefits from price transparency.

Uniform Compliance and Comparisons May Be Difficult

The Price Transparency Rule states that hospitals "must establish, update, and make public a list of all standard charges for all items and services online" as specified by the

rule.[23] "Items and services" are further defined as "all items and services, including individual items and services and service packages, that could be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge."[24]

The rule provides broad outlines for how hospitals can define services and service packages using Current Procedural Terminology codes, Healthcare Common Procedure Coding System codes, Diagnosis Related Group codes, National Drug Code codes, or any other code used by the hospital for the purposes of accounting or billing for an item or service. A broad definition is necessary because commercial payers are not uniform in how their managed care contracts are structured and paid. However, a broad definition will likely yield different interpretations among hospitals, which in turn will yield rate information that is not uniform between providers, making pricing comparisons by consumers difficult at best and meaningless at worst.

Since the Price Transparency Rule took effect in January 2021, we already see varying levels of compliance and uniformity in the information that is being posted by hospitals.[25] According to one recent report, some hospitals are providing this information in easy to find locations and formats, while others are offering up data streams that require a high level of expertise to understand.[26] Additionally, in a study of 100 hospitals, researchers found that 65 of them were "unambiguously noncompliant" as of February 2021.[27]

The "Health Care Market" Is Comprised of Multiple Markets

Health care services are delivered by providers to patients in many different settings and under vastly different scenarios, which present a challenge to CMS' assertion that price transparency will lead to lower health care costs. At one end of the spectrum, there is a "consumer market" for health care services that is subject to traditional market forces, where providers compete for business based on price and value delivered to the consumer. Non-emergency or elective services that have high out-of-pocket costs to the patient, such as outpatient imaging or some outpatient surgeries, lend themselves to being "shopped" around by a patient. For example, the study cited by CMS that showed how New Hampshire's price transparency initiative led to lower health care costs was focused on imaging services.[28]

Conversely, a significant volume of hospital care is delivered in an emergency or critical care setting, where it would be impractical if not impossible for a patient to compare prices between providers prior to receiving medical care. A parent whose newborn child requires a stay in the neonatal intensive care unit (NICU) is not going to shop for which hospital NICU has the lowest price for an equivalent quality of care; rather, they will utilize the NICU recommended by the physicians already involved during and immediately following delivery. Likewise, an individual experiencing a significant injury or life-threatening medical situation is more likely to seek care at the closest reputable medical facility, and published prices would likely have little to no impact on that

decision given the urgency of the situation and the time-intensive process of comparing prices.

In the middle of the spectrum, patients receiving treatment for chronic conditions or other ongoing care may be somewhat swayed by price but will largely base their decisions on history with a particular physician or provider group or the perceived quality of care provided, as evidenced by improved outcomes or public reputation of the physician, the facility, or both.

The Total Cost of Health Care Is Driven by Many Different Providers

Health care services in the United States are provided and funded by a complex web of providers and organizations that all contribute to the total cost of care. A simple hospital outpatient surgery typically generates bills from three different entities: (1) the physician or other provider rendering services, (2) the anesthesiologist, and (3) the facility where the procedure was performed. Complex inpatient surgeries may involve even more groups such as hospitalists or sub-specialty critical care physicians. This means the rate that the hospital receives for its services, and the related out-of-pocket expense paid by the patient to the hospital, is only one part of the overall cost picture because the patient will also be responsible for the amounts billed by the other providers involved in the case. Further, patients are heavily influenced by their doctor on which facility to use for services. This complexity makes the connection between posted prices and consumer action even more tenuous.

Medicare and Medicaid Are Significant Payers for Health Care

In 2019, Medicare and Medicaid made up almost 40% of total health care spending in the United States.[29] These payers reimburse for hospital services using fixed payment formulas that put significant downward margin pressure on hospitals. In fact, in many cases the Medicaid reimbursement is inadequate to cover the actual cost of care. As a result, hospitals often compensate for the low Medicare and Medicaid operating margins by negotiating commercial managed care reimbursement rates that are a significant premium relative to these government payers in order to achieve a sustainable economic result. The patient is far removed from these negotiations, and there are pricing pressures faced by hospitals that may outweigh any positive impact of price transparency.

Hospitals Set Contract Prices Based on a Mix of Inpatient and Outpatient Services

When hospitals and health systems negotiate rates for inpatient and outpatient services with commercial managed care payers, the negotiated rates are based on the payer's entire patient service mix rather than on discrete services. This approach can result in what is referred to as "cross subsidization," where some services have prices that yield a high profit margin and these high margin services subsidize other lower priced (or higher cost) services that have a negative margin. A set of contracted rates may yield a

market-level profit margin in the aggregate but have large swings of profits and losses at the service line level.

One effect of price transparency may be to lower prices for some services that lend themselves to being "shopped around," but raise prices for other, more price inelastic services such that the aggregate result for a particular contract remains approximately the same. Over the last ten years, hospitals have already seen downward price pressure on outpatient surgeries and other outpatient services (e.g., imaging services), as these services have moved from hospitals into specialized imaging centers and ambulatory surgery centers. Price transparency is likely to continue this trend.

Conclusion

Price transparency is a topic that has been a part of the health care discussion for over 15 years. Its current form represents the most extensive price disclosure requirements ever faced by hospitals and health systems. Cost containment achieved through increased provider price competition and efficiency is the goal, but it is still too early to tell what impact, if any, the Price Transparency Rule will have. Based on experiences in various states, there may be price reductions for some services, but this may be only a marginal change relative to the overall cost of health care. Disclosure rules may need further modification to promote greater compliance, data uniformity, and allow for better comparisons between hospitals. Whatever happens, the imperative to lower health care costs is not going away, and some form of price transparency will likely remain one of the many tools used to help achieve this goal.

Herd A. Midkiff, CVA is a Partner—Consulting Services with JTaylor. Herd has 24 years of experience serving a variety of clients in the health care, nonprofit, and investor-owned sectors. His fields of expertise include managed care contract negotiation support/analysis, health care analytics, and assisting in strategic planning and expansion projects. Herd also draws upon his health care and finance background to provide business enterprise and compensation valuation services. Herd's list of clients includes large multi-hospital health systems, physician-owned hospitals, private-equity investors, entrepreneurs, and attorneys. Herd is a member of the National Association of Certified Valuators and Analysts and is a Certified Valuation Analyst. Herd can be reached at 817.546.7036 or hmidkiff@jtaylor.com .

AHLA thanks the leaders of the Hospitals and Health Systems Practice Group for contributing this feature article: Emily Grey, Breazeale Sachse & Wilson LLP (Chair); Ritu Cooper, Hall Render Killian Heath & Lyman PC, Vice Chair—Educational Programming); Julia Tamulis, Bass Berry & Sims PLC (Vice Chair—Educational Programming); Kimberly Ruark, BakerHostetler (Vice Chair—Member

Engagement); Gregory Anderson, HORNE LLP (Vice Chair—Publishing); and Neerja Razdan, Beaumont Health (Vice Chair—Publishing).

---

1 84 Fed. Reg. 65524 (Nov. 27, 2019).
2 *See Bush Hints at Legislation on Price Transparency*, Commonwealth Fund (Feb. 15, 2006), https://www.commonwealthfund.org/publications/newsletter-article/bush-hints-legislation-price-transparency .
3 42 U.S.C. § 300gg-18(e) (2010) (emphasis added).
4 79 Fed. Reg. 49853-50536 (Aug. 22, 2014).
5 *Id*. at 50146.
6 83 Fed. Reg. 41144, 41686 (Aug. 17, 2018).
7 The hospital chargemaster contains a list of all hospital services that a hospital can bill to a payer or patient and each service's corresponding charge.
8 Exec. Order No. 13877, Improving Price and Quality Transparency in American Healthcare to put Patients First, *reprinted in* 84 Fed. Reg. 30849 (Jun. 24, 2019).
9 *American Hosp. Ass'n v. Azar*, 468 F. Supp. 3d 372 (D.D.C. 2020), *aff'd,* 983 F.3d 528 (D.C. Cir. 2020).
10 45 C.F.R. § 180.20.
11 45 C.F.R. § 180.40.
12 Shoppable service means a service that can be scheduled by a health care consumer in advance. *See* 45 C.F.R. § 180.20. Detailed requirements for the list of shoppable services can be found at 45 C.F.R. § 180.60.
13 45 C.F.R. § 180.90(c)(2).
14 85 Fed. Reg. 58432, 58891 (Sept. 18, 2020).
15 *Id.* at 58875, 58892.
16 Shira Stein, *Poison Pill Quiets Hospitals on Defying Price Transparency Rule*, Bloomberg Law (Sept. 16, 2020), https://news.bloomberglaw.com/health-law-and-business/poison-pill-quiets-hospitals-on-defying-price-transparency-rule .
17 85 Fed. Reg. at 58890.
18 84 Fed. Reg. at 65525.
19 *Id*. at 65526.
20 *Id*. at 65526–65527.
21 *Id*. at 65527.
22 *See generally American Hosp. Ass'n v. Azar*, 468 F. Supp. 3d 372 (D.D.C. 2020).
23 45 C.F.R. § 180.50(a).
24 45 C.F.R. § 180.20.
25 Michael Brady, *Hospitals Slow to Disclose Their Payer-Negotiated Rates,* Modern Healthcare (Jan. 8, 2021), https://www.modernhealthcare.com/transformation/hospitals-slow-disclose-their-payer-negotiated-rates .
26 *Id.*
27 Morgan Henderson and Morgane C. Mouslim, *Low Compliance From Big Hospitals On CMS's Hospital Price Transparency Rule*, Health Affairs Blog, Mar. 16, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210311.899634/full/ .

28 Zach Y. Brown, *Equilibrium Effects of Health Care Price Information,* 101(4) Rev. of Econ. & Stat. 699, 700–711 (Oct. 1, 2019), http://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf .
29 Centers for Medicare & Medicaid Services, *National Health Expenditures 2019 Highlights*, (Dec. 16, 2020), https://www.cms.gov/files/document/highlights.pdf .