When it Comes to the Price Transparency Rule, Not All Data is Created Equal

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Originally published in ABA Health eSource August 2021, Vol. 17 No. 11


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Introduction

On January 1, 2021, some U.S. hospitals began reporting information about their negotiated rates with payors in order to comply with the Centers for Medicare & Medicaid Services' (CMS's) recent Price Transparency Requirements for Hospitals to Make Standard Charges Public (Price Transparency Rule).[1] The Price Transparency Rule requires hospitals to make information for at least 300 billed charges and negotiated payments that the hospitals agree to receive from various payors.

The goal of the Price Transparency Rule is to reduce the cost of healthcare for consumers by making pricing information easily accessible and by increasing competition for the provision of healthcare services.[2] It is intended to provide individual consumers and other market participants with the data needed to understand what hospitals actually receive for individual services. Industry critics often point to the complexity of medical billing practices, the lack of transparency, and the difficulty of comparing payments that different providers receive for similar services as barriers to competitive pricing, and thus to reducing high healthcare costs.

How useful the Price Transparency Rule will be to consumers, and how effective it will be in controlling rising costs, should become clearer over time, as more and more

hospitals post and update the required information, and as more and more users become familiar with the data and how to use it appropriately. But this type of information is also much sought after in certain types of litigation over the "reasonable value" of healthcare services, such as in disputes over appropriate payments for out-of-network services. Heretofore, detailed data was largely unavailable, and the value of the services at issue often could only be pieced together through third-party discovery.

Now that several months have passed since hospitals began posting their price transparency data, it remains an open question to what degree the data hospitals have published can be used as intended. Hospitals' compliance with the rule's requirements is still evolving. Consequently, those seeking to use the data to support their arguments in litigation will need to proceed with caution.

If appropriate care is taken, the hospitals' published data can be used to develop a basic understanding of the level of payment each hospital receives for different services from contracted payors. However, the data available to date may be limited in its usefulness as published, and should be closely assessed for completeness and timeliness. Care must be taken to develop a detailed understanding of what an individual hospital's data does, and does not, represent.

Why is Transparency of Payments Important in Litigation?

Historically, hospitals did not disclose publicly the payments they received from different payors for the services the hospitals provided.[3] Prior to the Price Transparency Rule, it required a great deal of effort for even well-informed participants in the healthcare system to identify not only how much different hospitals charged for the same service, but also how much they ultimately accepted in payment for the service. The amounts that specific hospitals agreed to accept through willing-buyer/willing-seller negotiations with payors as payment in full were not publicly available, and research has demonstrated that the payments rarely equaled the hospital's full billed charges.[4] In fact, hospitals in the United States may charge any amount they choose, and may set charges that are arbitrary and unrelated to the cost of providing services.[5]

Consequently, the amounts that hospitals receive, rather than the amounts they bill, are the relevant metric when it comes to determining the reasonable value (a.k.a. market value) of hospital services. Not only is this supported by economic and valuation principles, but it has also been recognized by courts in disputes between hospitals and payors related to reimbursement for out-of-network services.

For example, in *Children's Hospital Central California v. Blue Cross of California*, the Court of Appeals for the Fifth Appellate District found that "full billed charges reflect what the provider unilaterally says what its services are worth" and that "[h]ospital[s] rarely receive payment based on its published chargemaster rates."[6] This finding is not unique to California. In *Baker County Medical Services, Inc. d/b/a Ed Fraser Memorial Hospital v. Aetna Health Management*, a Florida District Court of Appeal ruled that "usual and customary charges" does not refer to billed charges, but rather "the fair

market value of the services provided," and "[f]air market value is the price that a willing buyer will pay and a willing seller will accept in an arms-length transaction."[7]

It is this difference between billed charges and payments received that underscores the need to carefully examine and thoroughly understand the data published under the Price Transparency Rule.

Potential Issues with the Price Transparency Data that Users Should Consider Prior to Drawing Conclusions from the Data

The data hospitals provide in response to the Price Transparency Rule was intended to allow users to understand the level of payment hospitals and payors negotiated for different services. For example, the data theoretically could allow uninsured patients, or those paying for medical services through health savings accounts, to shop for value across different medical providers. Such data may also be useful in litigation that is related to the provision of and payment for healthcare services, where the reasonable payment for the services hospitals provide is often in dispute.

The data that hospitals have made available to date, however, presents potential pitfalls that a user of the data should consider prior to drawing any conclusions. In particular, users need to be mindful of various forms of non-compliance on the part of hospitals, as well as of differences in reporting from hospital to hospital and of underlying complexities that may limit the usefulness of the data as published.

Issues with Compliance and Timing Affect the Utility of Published Data

To date, the level of compliance among hospitals has been variable, but evolving. A *Health Affairs* article found that 65 of the 100 largest hospitals in the United States were "unambiguously non-compliant" as of late January/early February 2021 for reasons such as not including the payor-specific negotiated rates in the posted data or not posting any files or searchable databases.[8] Similarly, the Health Care Cost Institute found that, as of February 2021, only half of the 222 hospitals it examined "published negotiated prices in any manner, and only one-third published negotiated rates in a manner aligned with the regulation's intent."[9]

As of this writing, more hospitals seem to be complying, although compliance is still not uniform.[10] Even so, potential users of the data will need to start by confirming whether the data they seek is available, complete, and accurate.

Variations or Complexities in the Published Data May Mask Underlying Value

For data that is available, users still should consider any data complexities or differences in reporting that may impact their ability to use the data for drawing conclusions or limit the types of conclusions they may be able to draw from the data. Examples of these include the following:

1. Some hospitals posted files that do not include the full range of negotiated rates. For instance, one hospital posted a file that may appear to a user to provide payor-specific negotiated rates. However, upon closer examination, it is evident that the file includes only Medicare Advantage payors, and provides the same negotiated price for each payor.[11] Thus, the data's utility is restricted to this segment.
2. Some hospitals posted files that provide payor-specific negotiated rates, but anonymize the name of each payor.[12] While the data may be used to understand the range of negotiated rates, it limits the ability to evaluate negotiated rates paid by different types of payors (e.g., health plans, risk-bearing organizations, or leased network entities) that may face different constraints and/or have different incentives.
3. Users should be careful which version of a hospital's data is used, as some hospitals submit updated files. Hospitals may also need to update data they have already posted to comply with additional guidelines that the CMS may provide following its audit of a sample of hospitals for compliance,[13] investigation of complaints, or discoveries published by other parties. Consequently, users will need to monitor for updates pertaining to the datasets they have previously downloaded.
4. Some hospitals posted files with negotiated amounts that appear counter-intuitive and may require further investigation before being used to draw conclusions. For example, one hospital reported it had some contracts with negotiated rates for some services greater than full billed charges, such as a contract with negotiated rates that were 115 percent of billed charges for certain services.[14] While one cannot know if this is an error without access to the contract between the two parties, payors do not typically pay more than the hospital's full billed charges for hospital services.
5. Some contracts between hospitals and payors, especially those that are based at least in part on the hospital's full billed charges, may specify that the contract rate would be adjusted downward using a predetermined formula if the hospital's charges increase by a larger percentage than is permitted by the contract.[15] Given that the Price Transparency Rule does not require that the hospitals provide details about individual contract terms beyond the negotiated rate, a hospital

theoretically could indicate that its negotiated rate is, for example, 60 percent of charges (because this rate is explicitly specified in the contract), even though in fact it is currently paid a rate of 55 percent of charges.

6. Some contracts between payors and hospitals contain rates that are a specific percentage of billed charges for some services up to a certain threshold per visit — for example, 60 percent — and then cap all payments at that threshold no matter how high the billed charges are or how complicated the procedure is. Such an arrangement may result in an average payment rate, in this example, that is only 40 percent of charges. Payors and hospitals may also negotiate a higher rate for outpatient services in exchange for a lower rate for inpatient services, or vice versa.

In light of these issues that may affect the price transparency data, users of the data should carefully evaluate the published datasets to determine what they contain and the extent to which they might be useful for the desired purpose.

In addition, users should be mindful about reaching broader conclusions about the contractual relationship between hospitals and payors. A few health plan representatives have already commented on the difficulty of using the data to make broader conclusions about their contracts with providers. For instance, The *Wall Street Journal* quoted an Anthem spokesperson as saying that "looking at a list of prices without the full context makes it impossible to draw meaningful conclusions," and a Cigna spokesperson as saying that data examined for a limited number of services "is in no way indicative of value nor cost competitiveness" of Cigna's contracts.[16]

Conclusion

The data hospitals provide in response to the Price Transparency Rule is intended to allow users to understand the level of payment each hospital receives for different services from contracted payors. Data on the payment rates received by a provider is also sought in litigation involving disputes between hospitals and payors over the appropriate payment for out-of-network healthcare services. The Price Transparency Rule data may serve to supplement the types of data that are typically produced in these types of disputes.

However, to date, hospitals have varied widely in terms of their level of compliance and the completeness of the data they publish. The price transparency data that has been published often is complex, so an inexperienced user may stumble into various pitfalls when collecting and analyzing the data. Until compliance improves and the published data becomes more uniform, care will need to be taken in developing strategies for effectively leveraging the data.

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Footnotes

1 Health and Human Services Department, "Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public" (Nov. 27, 2019) (hereafter, the Price Transparency Rule).

2 *See, for example*, CMS, "Transparency in Coverage Final Rule Fact Sheet" (Oct. 29, 2020), *available at* https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f

3 Some states, such as California, had made steps towards price transparency by requiring hospitals to publish their charges for services and/or report aggregated information on the overall payment rate they received in aggregate from various payor categories (e.g., Medicare and commercial payors). In addition, a few states have published available transaction prices through consumer tools that leverage data submitted by payors to state databases (referred to as "all-payer claims databases"). *See, for example,* All-Payer Claims Database Council, "Interactive State Report Map," *available at* https://www.apcdcouncil.org/state/map

4 *See, for example*, Bai, G. & Gerard, A., "US Hospitals Are Still Using Chargemaster Markups to Maximize Revenues," *Health Affairs* 35(9) (2016); Brown, E., "Irrational Hospital Pricing," *Houston Journal of Health Law & Policy* (2014).

5 *See, for example*, Bai, G. & Anderson, G., "Extreme Markup: The Fifty US Hospitals With the Highest Charge-To-Cost Ratios" (June 2015), *Health Affairs* Vol. 34(6).

6 *Children's Hospital Central California v. Blue Cross of California*, 226 Cal. App. 4th 1260 (June 10, 2014), at 1275.

7 *Baker County Medical Services, Inc. d/b/a Ed Fraser Memorial Hospital v. Aetna Health Management, LLC*, 35 Fla. App. 1st D438b (Feb. 24, 2010).

8 Henderson, M. & Mouslin, M., "Low Compliance from Big Hospitals on CMS's Hospital Price Transparency Rule" (Mar. 16, 2021), *Health Affairs*, *available at* https://www.healthaffairs.org/do/10.1377/hblog20210311.899634/full/

9 Kennedy, K., et al., "The Insanity of U.S. Health Care Pricing: An Early Look at Hospital Price Transparency Data" (Apr. 1, 2021), *Health Care Cost Institute*, *available at* https://healthcostinstitute.org/hcci-research/hospital-price-transparency-1

10 A June report published by the consulting firm Milliman found that among 1,410 hospitals within the largest 100 health systems, 61 percent had published a machine-readable file that "primarily contains all reviewed elements." Barrington, A., et al., "Hospital Price Transparency: June 2021 Update," *available at* https://frm.milliman.com/-/media/milliman/pdfs/2021-articles/6 22 21-price_transparency.ashx

11 Scripps Price Transparency, *available at* https://www.scripps.org/patients-and-visitors/billing/price-transparency.

12 Verdugo Hills Hospital Price Transparency, *available at* https://www.keckmedicine.org/price-transparency-tool/

13 There is evidence that CMS is tracking the results of third-party examinations of Price Transparency Rule data and reacting to some of those findings by issuing new guidance to increase compliance. For example, after a *The Wall Street Journal* investigation revealed that some hospitals included code that blocked the webpage with the price transparency data from search engines, CMS issued guidance that these webpages should not be shielded from search engines. In a statement, CMS affirmed that the intent of the Price Transparency Rule is to "make the files public and accessible." Mathews, A.W. & McGinty, T., "Coding to Hide Health Prices from Web Searches is Barred by Regulators" (Apr. 14, 2021), *The Wall Street Journal*, *available at* https://www.wsj.com/articles/coding-to-hide-health-prices-from-web-searches-is-barred-by-regulators-11618405825

14 Los Robles Health System, "Pricing Transparency CMS Required File of Standard Charges," *available at* https://losrobleshospital.com/about/legal/pricing-transparency-cms-required-file-of-standard-charges.dot

15 An example of this would be a contract stating that the hospital is to be paid 60 percent of billed charges for outpatient services, and that the payment rate would be a lower percentage of charges if the hospital increases charges by more than five percent.

16 Mathews, A.W., et al., "How Much Does a C Section Cost? At One Hospital, Anywhere from $6,241 to $60,584" (Feb. 11, 2021), *The Wall Street Journal*, *available at* https://www.wsj.com/articles/how-much-does-a-c-section-cost-at-one-hospital-anywhere-from-6-241-to-60 584-11613051137.

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