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Hospital Price Transparency Regulation | Market Response

Post-1/1/21 Review

Responses to the January 1, 2021, Hospital Price Transparency Rule are varied and reflect the many strategic implications of increasing information transparency in Health Care

Background

The 2021 Hospital Price Transparency Rule went into effect on January 1, 2021 ("Rule") and requires hospitals to make public the "standard charges" for all items and services that a hospital provides, as well as prices for 300 shoppable[1] services in a consumer-friendly format. The definition of "standard charges" includes the confidentially negotiated rates between a hospital and third-party payors, including Medicare Advantage and Medicaid managed care plans. The rule also requires this information to be posted in a machine-readable[2] file format (MRF) and updated at least annually.

Within the Rule, two of the stated goals of price transparency are: (1) "to better understand how the level of price dispersion in various health care markets impacts health care spending and consumer out-of-pocket costs"[3] and (2) "to enable patients to become active consumers so that they can lead the drive towards value"[4].

In meeting the requirement for standard charges to be posted as a type of MRF, hospitals took different approaches to the format, data types, and names of standard data elements. Unlike the "Transparency in Coverage" final rule for payors released on November 12, 2020, the Administration did not provide any sample file schemas or formats for hospitals to use as a template. As a result, there is significant variation in the way hospitals have responded to these regulatory requirements.

Could variation in implementation across hospitals slow the push to consumerism, which is one of the intents of the regulation? As market reactions unfold, some of the other questions that may be asked include: Will variation in negotiated rates decrease? Will prices converge to the top, bottom or median of a market? How will consumers, employers, and/or payors use the newly available data? Transparency-driven change will take time; however, current market reactions provide a glimpse into the future state of health care markets.

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[1] A "Shoppable" service is defined as "a service that can be scheduled by a healthcare consumer in advance" per the Hospital Price Transparency Rule, 84 Fed. Reg. 65603 (November 27, 2019)
[2] Machine-readable format is defined "as a digital representation of data or information in a file that can be imported or read into a computer system for further processing, e.g., .XML, .JSON, .CSV" per the Hospital Price Transparency Rule, 84 Fed. Reg. 65603 (November 27, 2019)
[3] Hospital Price Transparency Rule, 84 Fed. Reg. 65548 (November 27, 2019)
[4] Hospital Price Transparency Rule, 84 Fed. Reg. 65526 (November 27, 2019)

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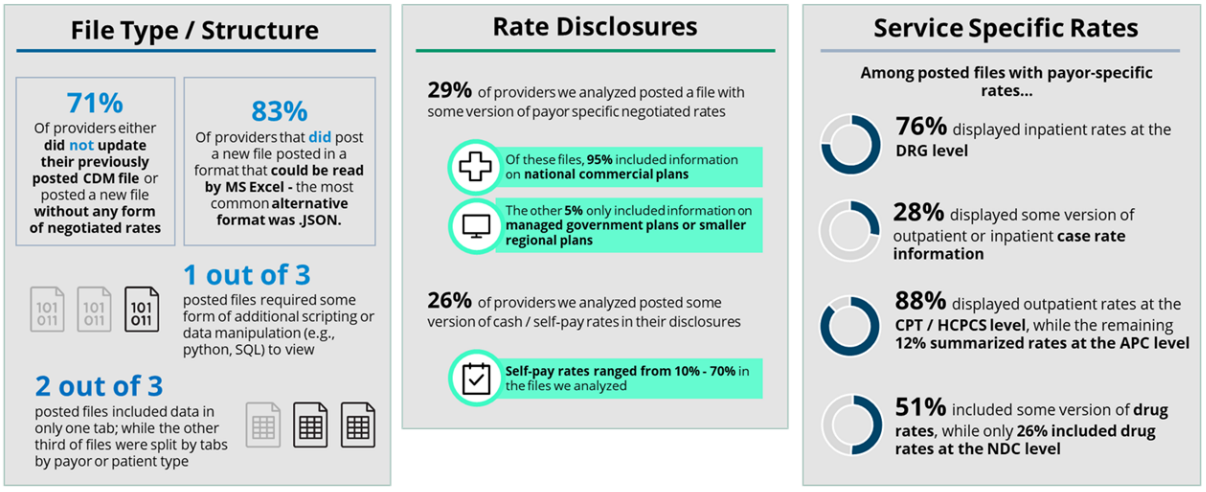
Our Analysis

In a review of more than 150 health care system websites, our research team reviewed the disclosures of a diverse sample of health care systems across geographies – ranging from national health systems to small regional providers, academic medical centers (AMCs), and specialty hospitals – to develop a representative view of hospital price transparency responses. This review resulted in collection of more than 60 MRFs, analysis of more than 50 data points within each file, and the build of a broad database detailing the breadth and depth of current hospital responses to the rule.

While we also performed separate analyses on the usability and completeness of the consumer "shoppable" files and tools, the focus of this research is solely on the MRFs and the potential impact they could have on market dynamics in the health care sector. It should be noted that in the absence of specific contractual language for these health care systems, we have not confirmed the accuracy of the rate data that has been shared.

Market Response

In choosing 86 individual hospital websites from the US News & World Report™ Honor Roll and Top Specialty Hospitals, our research revealed that only 29% of those hospitals have posted payor-negotiated rates.



Nation-wide providers N=86

The Non-Posters

Through a recent Deloitte Survey[5] of senior financial executives of major health care systems and an analysis of market sentiment, we believe there are two primary drivers leading organizations to withhold their rate data. First, the strain put on health systems by the COVID-19 pandemic and subsequent vaccination effort, along with already limited resources, have left many hospitals simply unable to dedicate the necessary resources to build a compliant, comprehensive file in a timely manner. To build the file, most hospitals require engagement from a cross-functional committee spanning multiple operational areas. This group typically extends beyond senior leadership in finance and revenue cycle and requires the additional experience of IT, managed care, compliance, legal, communications, and marketing. Strategic decision making from this cross-functional group is

[5] Phelps, Anne & Skalka, Christi. "Greater transparency and interoperability in health care." *Deloitte Insights*, 25 Jan. 2021, https://www2.deloitte.com/us/en/insights/industry/health-care/health-care-pricing-transparency-operability.html

required to create the files, and this process can be analytically and resource intensive. Once created, the file requires review for accuracy. Given the already stretched resources of these organizations, developing a quality file in a relatively short time frame likely posed a challenge.

Second, and perhaps more significantly, many hospitals are reluctant to be the first mover into the uncharted waters of price transparency. There are understandable hesitations around anticipated payor, media, government and/or consumer reactions to the publicized rates. These rates have been a closely guarded secret within the industry for decades, and for some health care systems in extremely competitive markets, they are likely the source of their competitive edge.

Merging these two primary drivers into combinations of a hospitals ability to allocate resources to the MRF effort (i.e., high and low readiness) and the competitiveness of their geographic or peer market (i.e., high and low stakes) results in the following potential strategic positions of these non-posters:

- **High Readiness/Low Stakes:** These hospitals have a file developed and are capable of posting but may be operating in a low-stakes competitive environment, which allows them the opportunity to delay publishing their rates.
- **High Readiness/High Stakes:** Price transparency may be top-of-mind for these hospitals and they have a file ready to go, but because they operate in a highly competitive environment, there may exist perceived risks or apprehensions associated with posting.
- **Low Readiness/Low Stakes:** Potentially the most enviable of positions, these hospitals are slowly piecing together their files, and are not experiencing payor, consumer or media pressure to rush their posting.
- **Low Readiness/High Stakes:** These hospitals potentially did not have capacity to prepare for a January 1st, 2021 posting, but find may themselves in an environment where there is significant payor, patient, or media scrutiny, applying pressure to disclose.

Approximately 70% of the health care systems we analyzed have not posted their rates. The risks of not posting include potential regulatory implications of non-compliance, the most extreme of which may likely result in a civil monetary penalty that could be published on the CMS (Centers for Medicare & Medicaid Services) website[6]. Other potential liabilities include the near-term potential for drawing negative media attention and longer term, potentially losing market share to hospitals that choose to use the transparency imperative to differentiate their value through price and patient experience.

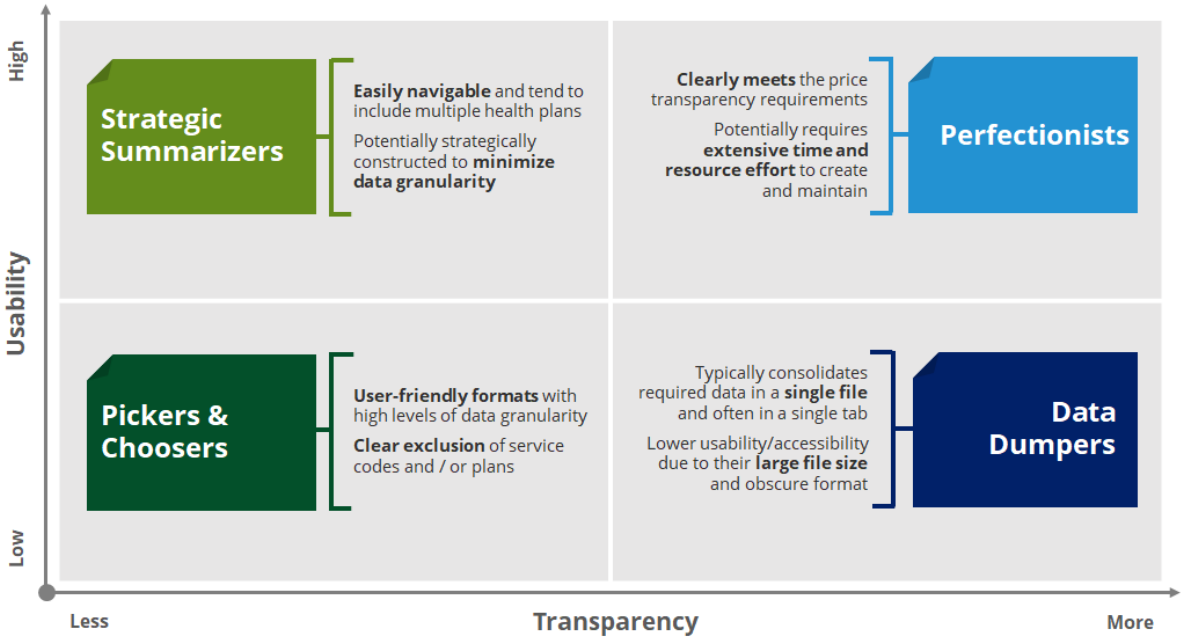
For hospitals that have not posted any MRF or rate information yet, they may have done this for strategic reasons, such as waiting for their peers to react and for the national MRF data integrity to improve. This could theoretically give the health care system intelligence on key components of their own MRFs and may delay the potential impact to vulnerable payor rates from both competitors and data aggregators. The risks and strategic considerations of not posting should continue to be assessed to determine the path forward for these systems.

The Posters

Among hospitals that did choose to post a file, there are emerging trends in how each has interpreted the regulatory requirements. There is clear differentiation among hospitals and health care systems who have opted for the increased levels of transparency; these providers have included services, items, service packages, and plans within their files of charges and rates. Others have chosen a more selective manner of transparency, including only a subset of services or plans, or sharing rates at a summarized level. To categorize the files, we developed a rubric based on the file construction, including the file size, data display and file format; the apparent completeness of

[6] Hospital Price Transparency Rule, 84 Fed. Reg. 65604 (November 27, 2019)

the data based on the number of items, services, plans and products; and the usability and accessibility of the file by a layperson. Ultimately, the hospital disclosures we analyzed can be segmented into four major archetypes based on this rubric:



"Data Dumpers"

The most prevalent type of MRF data file found in our analysis, and possibly the most straightforward in its creation and implementation, the "Data Dumper" consolidates required data in a single data sheet, and often layers multiple required data elements into a limited number of data fields. At first glance, these files appear to include the required data elements but appear to have low usability and accessibility due to their size (i.e., multiple gigabytes) and machine-readable format (i.e., .JSON). These files also appear to be outputs of hospital financial systems, which can contain logic that calculates the expected payment based on the contractual provisions of third-party contracts.

"Pickers and Choosers"

While these files are often more user-friendly than the Data Dumpers in terms of size and file format, the "Pickers and Choosers" appear to have prioritized simplicity and speed over obvious completeness. There is clear, potentially strategic, exclusion of particular items and services and / or plans making rate transparency lower than other archetypes. The lack of depth, however, lends itself to potentially less resource-intensive construction and may give the provider time to make strategic decisions on what items, services and plans to publish.

"Strategic Summarizers"

"Strategic Summarizers" tend to have easily navigable files in terms of size and file format, and appear to represent all items, services, payors and plans. Their defining characteristic is that they typically choose to identify negotiated rates by APC for outpatient services and DRG for inpatient services. Because of this package-based representation, the usability is rather high, providing a comprehensive view of each service, but the ability to directly compare rates to the other file archetypes is obscured. Occasionally, there is additional strategy embedded in the file construction – for example, blinding names of payors or plans within the file.

"Perfectionists"

As the name suggests, the "Perfectionists" seem to have gone to great lengths to confirm they meet all details of the regulation clearly, and in some cases go above and beyond in their transparency. These files were the least prevalent in our data set – only a handful. These files include industry standard billing codes, service packages[7], health plan names, and other reimbursement details to construct a near-exact payment estimate for all inpatient and outpatient services. Although their files may be closest to meeting the full intention of the regulation, the lift required for building and maintaining this type of file may be extensive.

Approximately 30% of the hospitals in our sample have posted files (as of the date of this publication). Hospitals that fully complied in a timely manner may have given themselves the first mover advantage, potentially setting reference prices in their markets and establishing industry norms. Additionally, there is likely less risk of a CMS audit. Along with the potential benefits however, there are valid concerns associated with the potential responses of payors, competitors, consumers, media and researchers/watchdogs to the public display of this once-confidential data.

The Path Forward

Analysis of market reactions to the price transparency rule has revealed significant variation in hospitals' responses to the federal regulation. What is clear is that the information transparency imperative in health care is increasing and driving organizations to act.

Regardless of their current position, organizations should use these early days of transparency to be thoughtful about their response, their peer's responses, and how transparency might change the way they collaborate with payors, compete with other providers, and manage the patient experience.

If hospitals are not currently in a position to post their MRFs, it will be important to clearly define and monitor the external triggers that will likely cause them to publish. These triggers could include monitoring their competitive environment, observing the tenacity of CMS auditing efforts, and checking in with what the media and other health care watchdogs are saying. Equally as important, though, are sensing the sentiments of internal influencers such as the board, executive leadership, and other key stakeholders.

For most hospitals, it will be important to begin the benchmarking process as efficiently as possible, measuring their payor negotiated rates against the disclosed rates of their comparators to get a comprehensive understanding of market position. This effort is a complex analysis involving a deep understanding of contract terms, analytical capabilities and the ability to harvest, cleanse and transform data from comparator MRFs, followed by the involvement of managed care and payor strategy professionals to assist in understanding data quality and contract nuances. In order to fully harness the benefits of the newly transparent data, this effort should be an ongoing process as new rates are added and refreshed in the market, potentially requiring machine learning and AI capabilities to continuously mine and make sense of the available data. The insights gained from these analytics should be used to refine a health care system's value proposition to its' consumers and its' payor partners if market share and rate position are going to be protected.

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[7] Service packages are defined by the CMS as, "an aggregation of individual items and services into a single service with a single charge"

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We've identified the following no-regret moves to prepare for and succeed in this increasingly transparent market:

- Define a peer group and leverage data to benchmark your prices, rates, and cash discounts objectively; determine how these rates may play into upcoming contract negotiations
- Consider the signals you're giving to the market by disclosing your rates and address them directly to deliver your intended message
- Remember the goal of price transparency is to empower the consumer – design around their experience and determine how to communicate your value

Organizations that build and operationalize these capabilities will likely position themselves favorably as the market becomes even more transparent, notably continuing with the Transparency in Coverage rule that will require payors to disclose in-network, out-of-network and pharmacy payment information starting on 01/01/2022.

As price transparency evolves, the healthcare ecosystem will need to work together to agree on the metrics and tools that can help enable the consumer to make decisions based on value. Market and information transparency is acknowledged by some economists as a pre-requisite to efficient markets. A recent Deloitte Survey[8] of 30 senior hospital finance executives highlighted that 62% of respondents believe a transparent market will improve care coordination and quality of care. Additionally, most respondents intend to heavily focus on enhancing consumer engagement capabilities at their health systems. While there is a long road ahead to achieve meaningful transparency, hospitals who have posted have started down the path of truly transforming the industry.

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[8] Phelps, Anne & Skalka, Christi. "Greater transparency and interoperability in health care." *Deloitte Insights*, 25 Jan. 2021, https://www2.deloitte.com/us/en/insights/industry/health-care/health-care-pricing-transparency-operability.html