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The Nitty-Gritty of Price Transparency

By JoAnna Younts and Greg Russo, Berkeley Research Group, Washington, DC

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Introduction

Transparency has become a popular buzzword among media outlets, in political circles, and in various industries across the United States, including healthcare. In the healthcare space, transparency refers to prices, specifically contracted or negotiated rates. Historically, the Federal Trade Commission (FTC) has been wary of price transparency, especially in the healthcare market. In a 2015 article regarding healthcare price transparency, staff from the FTC's Office of Policy Planning stated, "We are especially concerned when information disclosures allow competitors to figure out what their rivals are charging, which dampens each competitor's incentive to offer a low price, or increases the likelihood that they can coordinate on higher prices."[i] The federal government has taken enforcement actions over the past several years to ensure that pricing information has not been shared among competitors.[ii]

In a seemingly contradictory move, the Trump administration pushed for price transparency in healthcare as a means to control costs and in mid-2019 issued an Executive Order requiring the publication of rates.[iii] The contradictions between the Executive Branch's order and the FTC's publication have not been resolved. Nevertheless, hospital contracted rates are being unveiled as the result of two rules published by the Centers for Medicare & Medicaid Services (CMS) with effective dates that are a year apart: the Hospital Price Transparency Rule and the Payer Price Transparency Rule.

CMS' Hospital Price Transparency Final Rule went into effect on January 1, 2021.[iv] Under this rule, all hospitals are required to provide pricing information online about the items and services they provide, including the contract rates they have negotiated with payers and the prices they accept from cash-paying patients. This rule has been effective for more than six months, but many hospitals have not complied with the reporting requirements, in part because of generally modest (especially for large systems)[v] financial penalties for not complying. While this rule has affected the marketplace, the focus of this article is the Payer Price Transparency Final Rule.

CMS' Payer Price Transparency Final Rule will go into effect on January 1, 2022. Similar to the Hospital Price Transparency Rule, the Payer Price Transparency Rule requires health insurers to post the rates they have negotiated with the hospitals in their networks, as well as historical out-of-network allowed amounts and drug prices.

While the Payer Price Transparency Rule is silent on the exact penalty calculation for health insurers, it implies that the amounts could be significant, which raises questions about the potential flood of data that could suddenly become public next year. This data would present both challenges and opportunities, as payers and providers potentially have the ability to use it to shake up negotiations.

Overview of the Payer Price Transparency Final Rule

The Payer Price Transparency Rule has two central requirements. First, payers must develop a self-service tool allowing members to evaluate out-of-pocket costs for specific services at a specific institution. Second, a payer must publish, on its website, "machine-readable files," meaning files in a format (such as Excel) that can be downloaded easily. Three sets of information must be published:

1. In-network negotiated rates: This file must include negotiated rates for all services and items between the health plan and an in-network provider.

2. Historical out-of-network allowed amounts: This file must include data on historical out-of-network claims, which must number at least 20 claims. The data must include billed amounts and payments.

3. Drug pricing information: This file must list the negotiated payment rate and historical net prices for all covered pharmaceuticals at the pharmacy level.

CMS requires that this data be published for all plans that were created after March 23, 2010 (the date of enactment of the Patient Protection and Affordable Care Act (PPACA)) and subject to the provisions of PPACA.

The Rule's Intent

Healthcare consumers have long possessed a certain level of complacency about the prices that are paid for healthcare services, because of the central role that health insurers play in negotiating rates and paying for healthcare services on members' behalf. Consumers with relatively generous benefit plans and low cost-sharing requirements could ignore the prices that their health plans paid for the services they received. However, as more consumers have shifted to products with higher cost-sharing requirements and health savings accounts over the past decade, out-of-pocket spending has increased: from $301 billion in 2010 to $407 billion in 2019 (a 35 percent increase).[i] Nearly 46 percent of people under the age of 65 with private health insurance were enrolled in a high deductible plan in 2018,[ii] and the average annual deductible for plans sold on the PPACA exchanges was $2,825 in 2021.[iii]

With increases in out-of-pocket spending, consumers likely will continue to focus more attention on the costs of healthcare services. In a 2017 survey of healthcare consumers, 71 percent of respondents said that out-of-pocket spending was either important or very important to them when choosing a doctor, and 72 percent agreed or strongly agreed that if more people compared the cost and quality of medical services, it would be good for the country.[iv] At the same time, only 13 percent of survey respondents had looked for information about the costs before receiving healthcare services, and just three percent had compared costs across providers. The primary reason that survey respondents did not seek price information was that they did not know where to find it. In fact, 75 percent of survey respondents said that they did not know of a resource that would allow them to compare costs among providers.[v]

Trends like these convinced lawmakers to push for transparency rules that would force both providers and payers to publish their negotiated rates. The Payer Price Transparency Rule states that "transparency in health coverage requirements will strengthen America's health care system by giving health care consumers, researchers, regulators, lawmakers, health innovators, and other health care stakeholders the information they need to make, or assist others in making informed decisions about health care purchases."[vi]

Whether the rule will have its intended effect on consumers continues to be debated and will require studies in the future. There also may be some as yet unknown consumer-related legal implications. In the meantime, the rule will create immediate challenges and opportunities that health plans, providers, and consumers may face as the data becomes public.

Challenges and Opportunities for Health Plans

First and foremost, the Payer Price Transparency Rule has the potential to completely change the nature and dynamic of payer-provider contracting and negotiations. Having reimbursement data that is theoretically available for all parties could result in more abbreviated contract negotiations. However, the key question is: Will the presence of pricing data result in a more level playing field between providers and payers? After all, payer–provider contract negotiations always have been about market power, with neither party (payer nor provider) having a full picture of reimbursement. Historically, a payer knew what it would pay its contracted providers but not what other payers paid the same providers. Likewise, a provider knew the reimbursement amounts it would receive from each payer but not the rates paid to other providers in the market for the same services. The availability of the transparency data may change the existing power balance. In some cases, the data may exacerbate or intensify existing market dynamics. In others, it may not have a noticeable impact.

Whether and how much the data may impact contract negotiations will depend on the specific market and the service mix of the providers within each market. For example, in markets with a high concentration of competing hospitals, transparency data may give payers an advantage, because it may result in rates converging to the lowest published rate for certain hospitals. These hospitals then would need to demonstrate higher quality or that they provide certain critical services to fend off price reductions.

By the same token, the value proposition for some hospitals may become more important as the data becomes public. For example, a hospital that has demanded high rates but that payers historically viewed as critical to their networks may see its market power diminish in the face of the transparency data. While the payers in that market may have known the hospital was the most expensive, the data will show exactly how much more expensive, thereby creating pressure on the hospital to justify its high rates.

Aside from the direct impact on rate negotiations, the transparency data could affect utilization as payers leverage their ability to direct members to certain lower-cost providers. This could be a powerful weapon for the payers, as providers could be forced to either accept lower rates during the negotiation process or experience reductions in volume.

In some markets, certain payers have wielded market power by paying market rates at or below the median to some or all hospitals in their networks. Once the transparency data becomes public, other payers may be able to use the data to leverage competitors' lower rates to put pressure on network hospitals. There have been numerous cases where, unbeknownst to some of the largest payers in a market, another (smaller) payer has negotiated

lower rates with a certain hospital. The lower rate is acceptable from the hospital's perspective, because the rates paid by the largest payers would typically cover the hospital's costs. But this scenario works only when there is a lack of transparency in the market. With transparency data, payers will see when another payer undercuts market rates or reimburses at above-market rates.

Transparency data also may prompt the marketplace to speed up its adoption of value-based payments, which have been a goal of the U.S. healthcare system for many years. First, payers have an opportunity to use the data to define their networks better and require providers to earn inclusion in those networks based on quality. In some cases, plans may agree to smaller discounts for providers who can clearly demonstrate the highest quality, but, more importantly, they will have the ability to drive larger discounts from hospitals that cannot demonstrate higher quality or simply steer members away from these providers altogether.

On the other hand, the availability of the data could, in certain circumstances, affect the payer–provider dynamic by potentially, over time, eliminating the need for insurers as middlemen. Insurers have historically served as experts on provider reimbursement and negotiation for self-funded employer health plans. However, employers could use the transparency data to eliminate insurers from the equation and directly contract with hospitals, at least for certain services.

These types of opportunities and challenges may be what CMS intends to create by implementing the Payer Price Transparency Rule, hoping that these types of situations can reduce prices and ultimately benefit consumers through lower cost-sharing. If the Payer Price Transparency Rule is going to have its intended effect, payers and providers will need to be savvy. Payers can and do steer members to certain providers via "carrots" (lower or no cost-sharing), "sticks" (no out-of-network coverage or higher cost-sharing for using out-of-network providers), or both (narrow networks). And most hospitals have historically been willing to provide discounts in exchange for assurances that a payer's members will be directed to the hospital. The extent to which payers or providers use the data remains to be seen, but it is likely to have a significant impact, and both parties should assume that the other is using the data to create a competitive advantage.

Challenges for Consumers

The Payer Price Transparency Rule includes a requirement that payers publish a tool that consumers can use to better understand the overall costs of services they need, as well as their out-of-pocket costs. However, consumers may not find the data to be as useful as the government hopes. Unlike many other products and services that Americans buy, healthcare services — and reimbursement for them — are complex. From a clinical standpoint, there is considerable variation in what may sound like the same thing. For example, there is a significant difference between a spinal fusion without complications (MS-DRG 473) and one with major comorbidities or complications (MS-DRG 471). Medicare pays about twice as much for MS-DRG 471 than for MS-DRG 473.

Further, consumers rarely understand the nuances of bundling methodologies or certain types of global rates. In addition, without clear quality metrics to accompany the data, consumers may find it difficult to interpret the prices they see. Thus, the data presents an opportunity for payers to educate consumers about how services are paid for. But make no mistake: This is not a "field of dreams" scenario. In other words, just because the payers build these tools and release the data does not mean that consumers will actually use them. Payers will need to actively engage and educate members about how to use the data so that they better understand what the members are actually paying for.

Conclusion

The Payer Price Transparency Rule and the Hospital Price Transparency Rule will create opportunities and challenges for payers and providers. Whether publishing pricing data will prompt price increases or decreases remains to be seen, but what *is* certain is that payers and providers will need to leverage the data if they want to preserve their market position. Those who simply ignore the data may find themselves at a significant disadvantage in contract negotiations and in identifying strategies to stay competitive in the increasingly consolidated healthcare marketplace.

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the opinions, position, or policy of Berkeley Research Group, LLC or its other employees and affiliates.

Footnotes

1. Koslov, T.I. & Jex, E., "Price Transparency or TMI?" Federal Trade Commission (FTC), Office of Policy Planning (July 2, 2015), *available at* https://www.ftc.gov/news-events/blogs/competition-matters/2015/07/price-transparency-or-tmi.

2 Meier, M.H., Albert, B.S., & Monahan, K., *Overview of FTC Actions in Health Care Services and Products*, FTC Health Care Division, Bureau of Competition (June 2019), ***available at*** https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview_health_care_june_2019.pdf

3 American Hospital Association, *President issues executive order on price transparency* (June 24, 2019), https://www.aha.org/news/headline/2019-06-24-president-issues-executive-order-price-transparency

4 The American Hospital Association attempted to prevent the implementation of this rule by filing a lawsuit against the Department of Health and Human Services. This attempt was not successful.

5 The Hospital Price Transparency Rule indicates that noncompliance will result in a civil monetary penalty of up to $300 per day per hospital or a maximum of $109,500 per year.

6 Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Fact Sheet, Table 3 (2019), ***available at*** https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet#:~:text=Historical%20NHE%2C%202019%3A&text=Private%20health%20insurance%20spending%20grew,the%204.2%25%20growth%20in%202 This is the most recent data available.

7 National Center for Health Statistics, NCHS Health Insurance Data: Fact Sheet (July 2019), p. 2.

8 CMS, 2021 Open Enrollment Report, p. 6, ***available at*** https://www.cms.gov/files/document/health-insurance-exchanges-2021-open-enrollment-report-final.pdf. This is the most recent data available.

9 Mehrotra, A., Dean, K.M., Sinaiko, A.D., & Sood, N., "Americans Support Price Shopping For Health Care, But Few Actually Seek Out Price Information," *Health Affairs 36*(8) (2017), 1392–1400, ***available at*** https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1471.

10 *Ibid.*

11 Final Rule, 85 Fed. Reg. 72158 (Nov. 12, 2020), ***available at*** https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage.

About the Authors

JoAnna Younts is a Director in BRG's Health Analytics Practice. She has worked in the healthcare industry for over 31 years and has provided strategic advisory services as well as expert support in disputes and investigations regarding billing and coding, provider costs, and reimbursement rates. She has worked with a variety of providers, payers, and government agencies, including hospitals, physicians, commercial health plans, and state correctional health systems on issues including evaluation and modification of reimbursement approaches, billing and claims analysis, reimbursement benchmarking, and fee schedule design. Ms. Younts has extensive experience in hospital reimbursement. She assisted the federal government on the original resource costing study that formed the basis for Ambulatory Payment Classifications used in the Medicare Hospital Outpatient Prospective Payment System (OPPS). She has advised in the development of reimbursement methodologies for out-of-network hospitals and ancillary providers. For providers, Ms. Younts has provided consulting support on a variety of reimbursement issues as well as contract modeling and impact analyses. She may be reached at jyounts@thinkbrg.com.

Greg Russo is a Managing Director in BRG's Health Analytics Practice. He specializes in providing strategic advice to healthcare organizations through his use of complex data analyses and financial modeling. His clients typically seek his expert understanding of the regulatory environment in which healthcare organizations operate. He utilizes large, multi-part data sets in providing clients with strategic advice as it relates to damage calculations, government investigations, internal investigations, business planning, and provider reimbursement. In his more than 15 years of experience, Mr. Russo's services have related to both litigation and non-litigation issues for health insurers and provider organizations. He may be reached at grusso@thinkbrg.com.