MILLIMAN WHITE PAPER

Hospital price transparency: Impact of the shoppable file

Josh Reinstein, FSA, MAAA
Phil Ellenberg, MS

Milliman

On November 1, 2019, the Centers for Medicare and Medicaid Services (CMS) released a final rule establishing requirements for hospitals operating in the United States to make public a list of their standard charges for the items and services they provide.[1] The final rule went into effect on January 1, 2021.

One of the provisions of the final rule requires hospitals to publish standard charges for 300 shoppable services. CMS has issued a list of 70 services that are required to be included on the shoppable file. Hospitals are given the choice of the remaining 230 services that will be included in their shoppable file. Using 2018 Marketscan Commercial data, this paper looks at the cost variance for the 70 shoppable services and the potential cost savings if these services move to lower-cost providers.

CMS has deferred to state agencies' licensing guidelines with respect to which entities qualify as a hospital. The regulations define a hospital as "an institution in any State in which State or applicable local law provides for the licensing of hospitals, that is licensed as a hospital pursuant to such law, or is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standard established for such licensing." This includes Critical Access Hospitals (CAHs), Inpatient Psychiatric Facilities (IPFs), Sole Community Hospitals (SCHs), and Inpatient Rehabilitation Facilities (IRFs), but does not include ambulatory surgical centers (ASCs) or other free-standing facilities. Federally owned or operated hospitals are exempt from the rule, as they do not negotiate rates with third-party payers.

The regulations adopted in the final rule require hospitals to publish standard charges for items and services. CMS defines "items and services" 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." Examples of items and services that would apply include supplies, room and board, and medical procedures, as well as services provided by employed physicians and non-physician practitioners who are employed by the hospital. Examples of service packages include, but are not limited to, bundled payment arrangements, per diem contracts, and inpatient case rates.

There are five types of standard charges that hospitals are required to make public:

1. **Gross charge amount**: The charge for an individual item or service that is reflected on a hospital's chargemaster, absent any discounts. This would not include any standard charges for service packages. This is commonly referred to as the "billed amount."
2. **Payer-specific negotiated charge**: The charge that a hospital has negotiated with a third-party payer for an item or service. This excludes Medicaid or Medicare fee-for-service (FFS) rates, as they are not negotiated payments. This amount is commonly referred to as the "allowed amount."
3. **Cash discounted price**: The charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service. Hospitals that do not offer cash discounts must instead display the hospital's undiscounted gross charges.
4. **De-identified minimum negotiated charge**: The lowest charge that a hospital has negotiated with all third-party payers for an item or service.
5. **De-identified maximum negotiated charge**: The highest charge that a hospital has negotiated with all third-party payers for an item or service.

The regulations require hospitals to publish their standard charges in two ways: 1) a comprehensive machine-readable file that makes public all standard charge information for all hospital items and services, and 2) a consumer-friendly display of 300 shoppable services derived from the machine-readable file.

[1] The full text of the final rule (45 CFR Part 180) with comments is available at https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and

Mandatory services

CMS prescribed 70 services (based on 74 CPT/HCPCS/DRG codes) that hospitals are required to include in the shoppable file. If a hospital does not offer one or more of these services, it must include another service in order to reach 300 total services in the shoppable file. The 70 services include surgical services (34% of codes), pathology/laboratory services (23%), and radiology services (18%), with the remaining 25% composed of professional services.

On a nationwide basis, these shoppable services account for 12% of total allowed costs. This percentage varies from 6% to 18% by metropolitan statistical area (MSA).[2]

We have included some example scenarios to illustrate the potential impact on allowed costs should healthcare consumers shift to lower-cost providers for the 70 CMS-prescribed shoppable services. If the average cost for all 70 of these services moved from the current mean to the XXth percentile, the savings would be:

Percentile	Savings as % of Shoppable Services*	Savings PMPM*
85th	-77%	-$23.39
75th	-35%	-$10.73
65th	-6%	-$1.84
35th	45%	$13.60
25th	54%	$16.34
15th	66%	$19.92

*Source: Calendar Year 2018 IBM Marketscan Commercial data. Results shown represent MSA-level results rolled up to the national level.

To compliment the examples above, we have developed an interactive supplement that allows users to explore the impact of moving from the average allowed cost to the XXth percentile allowed cost for each of the 70 CMS-prescribed shoppable services.[3]

Voluntary services

In addition to the 70 services prescribed by CMS, hospitals are required to publish the same information for an additional 230 shoppable services. Given that the additional 230 shoppable services are chosen by the hospitals, hospitals may be incentivized to cherry pick the services they believe the most favorable reimbursement rates in their given market, or alternatively, may choose less common services so as to not reveal their reimbursement rates for more common services.

We may see volatility in the 230 shoppable services shown by each hospital as it begins to see where it falls in the marketplace compared to other hospitals in its area. For example, if Hospital A does not list a code in 2021, but Hospital B does, and Hospital A has a lower price, Hospital A may be incentivized to show that service in 2022. In return, Hospital B may be incentivized to take that service off its list in 2023. Since hospitals can choose the additional 230 shoppable services themselves, it is impossible to quantify what percent of total costs will be impacted by these additional services.

Considerations

INABILITY TO SHOP BETWEEN PAYERS AND NETWORKS

While hospitals are required to provide pricing data for all payers, most healthcare consumers will be limited to shopping between hospitals as they cannot easily shift medical coverage from one payer to another. Moreover, if there are differences in price between networks for the same payer for the same service, healthcare consumers likewise cannot simply change networks or plans outside of open and/or special enrollment periods.

EASE OF FILE USE

A variable that will determine the impact of the comprehensive files is the ability to compare files between facilities. This will be driven by how standardized the files are across different hospital systems. It will also be driven by how convoluted the files are, as CMS has only prescribed that they be machine-readable. Independent organizations such as private companies, advocacy groups, and/or other governmental agencies may attempt to compile a consumer-friendly version of the files that contain prices for all hospitals in a given market. Milliman is currently working on compiling a consumer-friendly version of the files. Hospitals may also try to summarize the information published by their competitors in order to understand where they stand in the market.

WILLINGNESS TO TRAVEL

An additional consideration related to how healthcare consumers will use the files is their willingness and ability to travel for care. How far will consumers be willing to travel may vary by the type of service and by the potential cost savings.

BENEFIT DESIGN

The benefit design of a healthcare consumer's plan may impact how likely they are to seek out lower-cost facilities. If the consumer pays a flat copay, they have no incentive to make healthcare decisions based on price. Payers and employers have considered the impact that benefit designs have on consumer behavior for many years. The impact this rule has on healthcare costs may be influenced by plan benefit designs.

[2] The lower and upper range of total shoppable services as a percent of total costs reported represents the 1st and 99th percentiles of our data respectively.

[3] The interactive supplement to this paper is available at https://app.powerbi.com/view?r=eyJrIjoiNjQ0YzBkOTctNzAzNy00NGYwLTgyY2MtYzVhYjE1YzFhN2FmIiwidCI6ImUyNDBkNjFlLTYxZTMtNGM5ZS1hYjkwLTg2NDRiMmY0ZDJhOSIsImMiOjZ9

PHYSICIAN REFERRALS

Consumers may be dissuaded from using lower-cost facilities if their physician referred them to a specific facility for a given service. Historically, consumers usually receive services from providers they were referred to by their physician. This will impact how many healthcare consumers shift services to lower-cost providers, and which services are shifted.

IMPACT ON OTHER FACILITIES

Outside of hospitals, free-standing facilities (FSFs) such as ambulatory surgical centers (ASCs) may also face a new set of incentives with respect to price transparency. While there is no rule requiring FSFs to publish their prices, they may find it in their best interest to do so in order to attract healthcare consumers away from more expensive hospital settings. FSFs could pursue this by openly advertising their prices directly to consumers and by marketing directly to physician groups to seek increased referrals.

In addition, this consideration could create an information imbalance in the industry. If hospitals are forced to publish prices while other entities (e.g., FSFs, provider groups) are not, the non-hospital groups will have a knowledge advantage over their hospital competitors.

HOSPITAL/PAYER NEGOTIATIONS

With hospital/payer price negotiations, the shoppable files will decrease information asymmetry on both sides, which may lead to a flattening of prices for specific services in a given market. To offset potential revenue losses, hospitals may be incentivized to increase their prices on services not contained in the shoppable file. Hospitals will likely be in a position of needing to determine the true cost associated with each service to then determine the extent to which prices may be lowered before losing money. Hospitals may choose to offer certain services as a "loss leader" to get people in the door with the hope that they seek all of their care from the same hospital.

Hospitals and payers should also consider the type of hospital being included in the negotiations. If a hospital serves an area with a large percentage of uninsured consumers or those enrolled in Medicaid, it may need to negotiate higher commercial rates to compensate for the lower payment rates than another hospital that serves a population with a high rate of commercial insurance.

QUALITY

The rule is solely focused on price transparency and does not account for the quality of the care. As a consumer of any product will tell you, cheaper does not always mean better. Especially when it comes to personal well-being, consumers will likely be very concerned about the quality of the service, in addition to the price. If a hospital believes it offers higher quality than its competitors, it will need to find a way to convey that to consumers.

Data sources and methodology

The Calendar Year 2018 IBM Marketscan Commercial dataset was leveraged to complete the analysis contained herein. Marketscan contains data from a selection of large employers, health plans, and government and public organizations. Marketscan includes private-sector health data from approximately 350 payers. These data represent the medical experience of insured employees and their dependents.

To calculate the potential savings of moving from the average allowed cost to the XXth percentile allowed cost, we first found the XXth percentile allowed cost for each of the 70 CMS-specified shoppable services within each MSA for claims incurred in a hospital setting. We then rolled the MSA-level results up to the national level and compared the rolled-up national results for the XXth percentile to the national average allowed for each service.

Conclusion

The goal of the final rule is to make it easier for healthcare consumers to compare prices across hospitals for commonly performed procedures.[4] The overall impact on allowed costs, and therefore healthcare consumers' out-of-pocket costs, however, may be minimal. In addition to the considerations outlined herein, this is due to the typical costs associated with the 70 CMS prescribed shoppable services as well as the prevalence of such services. Moreover, this is driven by the distribution of allowed costs for each shoppable service across hospitals, which tends to be positively skewed. Positive skew means that higher-cost providers tend to be priced materially higher from the average cost than lower-cost providers are priced lower. In a market consisting largely of third-party payors and information asymmetry, increased price transparency can help healthcare consumers make better informed decisions to some extent. Healthcare consumers will continue to find it difficult to shop for services, however, without additional measures such as increased education around pricing and benefit design; increased communication between providers, payers, and patients; and real-time cost-sharing information. More readily available tools such as consumer-friendly price comparison applications, strengthened all-payer claims databases, and tagging electronic health records with price information would also enhance healthcare consumers' decision-making abilities.

CONTACT

Josh Reinstein
josh.reinstein@milliman.com

Phil Ellenberg
phil.ellenberg@milliman.com

[4] 84 FR 65524