CHCF Issue Brief

Pulling Back the Curtain:
How Many California Hospitals Are Complying with Federal Price Transparency Rules?

As of January 1, 2021, a new federal government policy required hospitals to release "clear, accessible pricing information about the items and services they provide" in two ways. First, they must post publicly on the internet a machine-readable file that includes information including both the amount they charge per service and the negotiated amounts they actually receive from payers. Second, they must provide information about prices for at least 300 services consumers might comparison shop for, in a consumer-friendly format. Hospitals can meet this second requirement by posting a machine-readable file of prices, or by providing a price estimator tool that would allow consumers to enter information and obtain individualized estimates of their out-of-pocket costs. Hospitals not meeting the requirement may be penalized by the Centers for Medicare & Medicaid Services (CMS).

A goal of the regulation is to improve price transparency, in the hopes that it will help efforts to manage health care costs, although debate continues about how big an impact the regulation could have, and early reports have shown that compliance with the new regulation is far from complete. This study was undertaken to see whether California hospitals were complying with the new regulations, as of April 2021. This brief summarizes results from the authors' analysis, which may be found in more detail in the full report, *Compliance with Price Transparency by California Hospitals*.[1]

Since the regulation applies to facilities with state hospital licenses, data from the California Office of Statewide Health Planning and Development were used to identify 522 facilities with California hospital licenses. The website of each hospital was searched between April 1, 2021, and April 30, 2021, seeking to identify information compliant with the price transparency regulations. The results were cross-checked with data from Turquoise Health, which has used automated methods to compile information reported by hospitals in response to the regulations.

Results are presented here for 391 general acute care, children's, and specialty hospitals covered by the regulation, excluding Kaiser hospitals. Limited results are presented for many other facilities with hospital licenses, behavioral health, and skilled nursing facilities, which often appear to have different pricing structures than the main group of facilities.

Compliance with the Regulations

For each hospital examined, measures of compliance were coded for several aspects of the first component of the regulation (the "Standard Charge" component). These measures follow the categories of information that hospitals are required to report. The measures included (1) whether the hospital provides any downloadable machine-readable file with prices; (2) whether the machine-readable file includes "gross charges," sometimes referred to as "chargemaster" rates; (3) whether the machine-readable file includes discounted cash prices — for example, those that might be offered to patients qualifying for discount programs; (4) whether the machine-readable file includes the de-identified minimum and maximum negotiated rates across payers with which the hospital contracts; and (5) whether the

1. Laurence Baker et al., *Compliance with Price Transparency by California Hospitals*, Stanford University — Stanford Health Policy, June 2021.

machine-readable file includes payer-specific negotiated rates for at least one identified payer and plan.

Figure 1 shows that while a majority of the hospitals provide some form of machine-readable file, only about one-third provided a file meeting all the criteria. Whether or not hospitals provide information about rates negotiated with specific payers has been of particular interest from a price transparency standpoint. About 45% of hospitals, 177 of 391, provided a file reporting at least some payer-specific prices.

Three measures of compliance were codified for the shoppable services component of the regulation, which requires that hospitals provide either a machine-readable file of prices for "shoppable" services, or an accessible tool from which consumers could obtain these prices. The measures used in this study were (1) whether the hospital provided a shoppable services machine-readable file, (2) whether the hospital provided a shoppable services online tool, and (3) for those that provided a tool, whether the tool could be used without account registration or disclosure of personal identifying information (PII).

Figure 2 shows that more than half of the hospitals provided an accessible tool for finding prices for a set of shoppable services, while only about one in five provided a file of shoppable services prices. 40 hospitals posted both a file and a tool. Overall, more than 60% appeared to be compliant with this component of the regulations.

Combining the results from the assessment of compliance with the first and second components of the regulation, an overall measure was constructed of whether hospitals appeared to be compliant with the regulation. Hospitals were classified as fully compliant if they met all criteria for the first component of the regulation and also provided either a shoppable services file or tool that was accessible without requiring a login or PII. Hospitals were classified as partially compliant if they posted at least a downloadable machine-readable file that was clearly distinct from a chargemaster, a shoppable services file, or shoppable services tool. Hospitals were classified as noncompliant if all of those three items (machine-readable file, shoppable services file, and shoppable services tool) weren't found.

Figure 1. Compliance with Standard Charge Component of Regulation, California, as of April 2021 (*N* = 391)

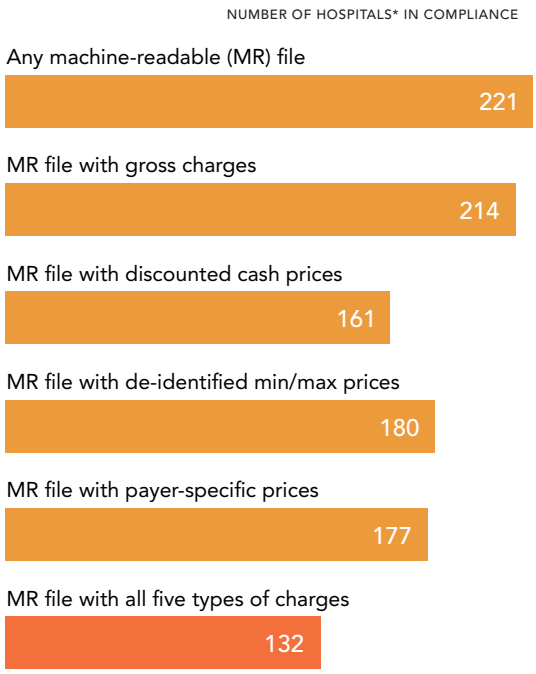
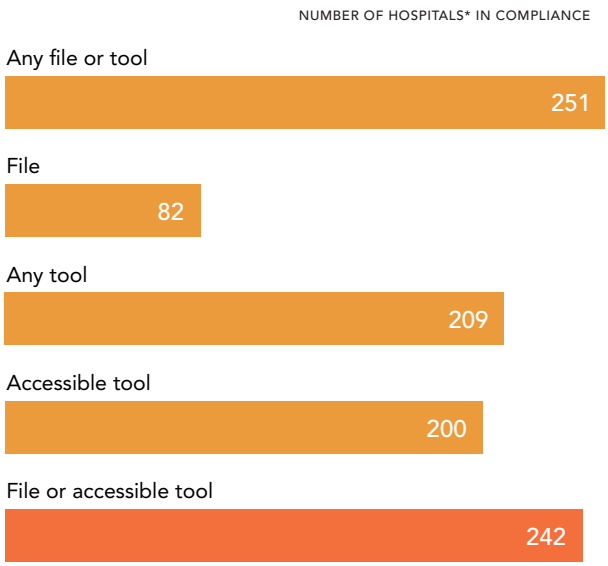


Figure 2. Compliance with Shoppable Services Component of Regulation, California, as of April 2021 (*N* = 391)



FIGURES 1 and 2:

*General acute care, children's, and specialty hospitals.

Source: Authors' analysis of information posted on hospital-licensed facility websites.

Thirty percent of hospitals (117 of 391) were identified as fully compliant, and 43% partially compliant, leaving 27% of the hospitals noncompliant with the regulation.

Also examined were other entities with California hospital licenses. These facilities are also apparently covered by the regulation but may operate substantially differently from the main group of general acute, children's, and specialty hospitals, and it is unclear how well the regulation fits them. Among 77 behavioral health facilities with hospital licenses examined, 9% were fully compliant and 19% were partially compliant, with 71% noncompliant. Among the 16 skilled nursing facilities we identified with hospital licenses, 13% were fully compliant with the regulation, 31% were partially compliant, and 57% were noncompliant.

Does Compliance Vary with Hospital Characteristics?

The authors obtained data about the characteristics of hospitals from OSHPD's 2019 hospital annual financial data, and about the characteristics of the county in which hospitals are located from the 2018–19 release of the Area Health Resources File. Then observations could be made about whether compliance rates varied according to characteristics of hospitals or the geographic areas in which they were located. Due to some limitations in data availability, these observations were able to be made for 329 of the 391 hospitals.

Table 1 shows that the largest hospitals by bed size were the least likely to be fully compliant but also the least likely to be non-compliant, as were teaching hospitals relative to non-teaching hospitals. Rural hospitals, and

Table 1. Compliance with Price Transparency Regulation, by Hospital and Area Demographic Characteristics, California

	FACTOR	NONCOMPLIANT	PARTIALLY COMPLIANT	FULLY COMPLIANT	P-VALUE*
Hospital-Level Data, 2019†					
▶ Licensed hospital beds	Small (1–100)	36 (38%)	29 (30%)	31 (32%)	.002
	Medium (101–499)	47 (23%)	93 (45%)	65 (32%)	
	Large (500+)	6 (21%)	19 (68%)	3 (11%)	
▶ Rural status	Nonrural	61 (22%)	126 (46%)	85 (24%)	<.001
	Rural	28 (49%)	15 (26%)	14 (25%)	
▶ Teaching status	Nonteaching	84 (28%)	123 (41%)	93 (31%)	.091
	Teaching	5 (17%)	18 (62%)	6 (21%)	
▶ Net patient revenue per patient day	Bottom quartile	23 (28%)	38 (46%)	22 (27%)	.86
	Middle 2 quartiles	46 (28%)	69 (42%)	49 (30%)	
	Top quartile	20 (24%)	34 (41%)	28 (34%)	
County-Level Data, 2017‡					
▶ In poverty	≤14.1%	31 (20%)	70 (44%)	57 (36%)	.007
	>14.1%	58 (34%)	71 (42%)	42 (25%)	
▶ Under 65 without health insurance	≤8.4%	37 (22%)	72 (42%)	63 (37%)	.010
	>8.4%	52 (33%)	69 (44%)	36 (23%)	

*Pearson's chi-squared test (categorical variables) was used for comparisons of compliance by hospital characteristics.

†Data in this section are from the *2019 CY Hospital Annual Selected File*, from the OSHPD Annual Financial Data. Includes general acute care, children's, and specialty hospitals (includes facilities with matched characteristics data; *N* = 329).

‡These variables are from the 2018–19 "Area Health Resource File."

hospitals in areas with higher shares of the population below the poverty limit and higher rates of uninsurance were less likely to be fully compliant and more likely to be non-compliant.

Comments

As of April 30, 2021, only 30% of the analyzed hospitals were fully compliant with new federal regulations requiring hospitals to report pricing data. This low level of compliance is consistent with other reports of limited compliance in other groups of hospitals around the United States. Somewhat higher rates of compliance, though still far from total, were observed with specific subparts of the regulation, including providing a resource for finding prices of shoppable services (compliance rate 64%) or providing a machine-readable file with payer-specific negotiated rates (compliance rate 45%).

Nearly half of hospitals complied with some parts of the regulation but not others, indicating awareness of the price transparency regulation but incomplete compliance with it. There are a variety of components with which hospitals could fail to comply. For example, many hospitals posted a file that included at least their "gross charges" but left out other required components. A common omission was prices specific to individual payers. For example, some hospitals included de-identified payer-specific rates but did not disclose names of insurers or plans. Another prominent hospital posted a file with a list of services and names of health plans but nearly every cell in the file listed the payer-specific negotiated rate as "variable" rather than as numeric values. For the shoppable services portion of the regulation, some hospitals posting an online tool had created barriers to using the tool (e.g., requiring a login or disclosure of PII) despite explicit warnings in the regulation not to do so. Other hospitals are using third-party platforms to host their pricing data, such as hospitalpriceindex.com and cdm-pricing.com, and in several cases these platforms did not correctly display the information from the hospital's file. It is unclear whether this issue is due to an unforeseen problem with the third-party software or lack of information in the hospital's file.

Reasons that hospitals are not fully compliant are not known. It is possible that some hospitals may be intending to comply, but it may take time to work out the requirements, which are extensive and unprecedented. It is possible that some hospitals may not be fully aware of the requirements. It is possible that some hospitals may have chosen not to disclose contract-negotiated rates that were previously considered proprietary information and may be willing to incur penalties that may be assessed for not doing so. Some may have been waiting to see if CMS would enforce the regulation. The agency began issuing warning letters to hospitals in May 2021, which may improve compliance rates over time. Hospitals identified by CMS as noncompliant will have 90 days to submit corrective action plans that address the issues before daily penalties are incurred. Overall, it remains uncertain how much, and how quickly, compliance might improve.

It is possible that hospital resources are associated with compliance. As was mentioned earlier, hospitals in counties with higher poverty and unemployment rates, and rural hospitals, were less likely to be compliant. On the other hand, the largest hospitals were also less likely than smaller hospitals to be fully compliant.

Additional efforts to identify reasons for noncompliance and to encourage increased compliance may be valuable, although debate about the potential impact remains. Greater transparency could theoretically help cost containment efforts by aiding consumers in their search for lower prices for services. For this to work, though, the information provided by hospitals would have to be accessible, comparable, and interpretable by consumers, and it is not clear that this is now the case. Based on this review, even when hospitals provide information, it is often complex and is not always comparable from one institution to another. Additionally, many patients who access health care may have limited choices of hospitals due to network restrictions, or may be seeking hospital care during a medical emergency.

Greater transparency could also affect costs if it influences contract negotiations between insurers and hospitals. This may offer more promise for contributing to cost containment, since hospitals, payers, and outside observers like news organizations that could publicly report on hospital prices may be both aware of the data and able to process and use them. More transparency about prices might put downward pressure on negotiated rates, though it has been noted that this need not be the case.

Ultimately, it is hard to argue against additional price transparency, although with limited compliance and uncertainty about how the data disclosed will be used, it appears that a considerable amount of additional work will be required to achieve the goals of the new regulation.

About the Authors

Laurence Baker, PhD, is professor of medicine (health policy) and senior fellow of the Stanford Institute for Economic Policy Research at Stanford University. Bianca Mulaney, MS, MPH, and Shreya A. Shah are Stanford University medical students; and Christine Kim is a predoctoral research fellow at the Stanford Institute for Economic Policy Research.

Acknowledgments

The analysis was supported by the California Health Care Foundation. The authors also thank Chris Severn and Jeff Littlejohn from Turquoise Health for their support.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.