**For project: National Hospital Price Transparency Study Using Limited Data Set Containing Protected Health Information**

This Data Use Agreement (the “*Agreement*”) is effective as of the date it is fully executed by the Parties (the “*Agreement Effective Date*”) and is made by and between [**Name Of Self-funded Employer]** (“*Covered Entity*”), [**Name Of Vendor/TPA]** acting on behalf of Covered Entity (“*Administrator*”), and **The** **RAND Corporation** (“*Recipient*”), a California non-profit corporation with IRS 501(c)3 status, (collectively referred to as the “*Parties*”).

WHEREAS, Covered Entity possesses Individually Identifiable Health Information that is protected under HIPAA (as hereinafter defined) and the HIPAA Regulations (as hereinafter defined), and is permitted to use or disclose such information only in accordance with HIPAA and the HIPAA Regulations;

WHEREAS, Recipient performs certain Activities (as hereinafter defined);

WHEREAS, Covered Entity and/or Administrator acting on behalf of Covered Entity wishes to disclose a Limited Data Set (as hereinafter defined) to Recipient for use by Recipient in performance of the Activities;

WHEREAS, Covered Entity wishes to ensure that Recipient will use and disclose the Limited Data Set solely for purposes of performing the Activities or as otherwise required by law;

WHEREAS, Covered Entity wishes to ensure that Recipient will appropriately safeguard the Limited Data Set disclosed by Covered Entity or by Administrator in accordance with HIPAA; *and*

WHEREAS, Recipient agrees to protect the privacy of the Limited Data Set in accordance with the terms and conditions of this Agreement and HIPAAs;

NOW THEREFORE, Covered Entity, Administrator, and Recipient agree as follows:

# 1. **Definitions.** The Parties agree that the following terms, when used in this Agreement, shall have the following meanings, provided that the terms set forth below shall be deemed to be modified to reflect any changes made to such terms from time to time as defined in HIPAA and the HIPAA Regulations.

## a. “*HIPAA*” means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended.

## b. “*HIPAA Regulations*” means the regulations promulgated under HIPAA by the United States Department of Health and Human Services, including, but not limited to, 45 C.F.R. Part 160 and 45 C.F.R. Part 164, as amended.

## c. “*Covered Entity*,” means a health plan (as defined by HIPAA and the HIPAA Regulations), a health care clearinghouse (as defined by HIPAA and the HIPAA Regulations), or a health care provider (as defined by HIPAA and the HIPAA Regulations) who transmits any health information in electronic form in connection with a transaction covered by the HIPAA Regulations.For purposes of this Agreement, “Covered Entity” means [**Name of Self-funded Employer**].

## d.“*Vendor*,” means any organization acting on behalf of the Covered Entity and who is currently conducting data collection efforts on behalf of the Covered Entity and which will work with the Covered Entity and Recipient to process any health information in electronic form in connection with a transaction covered by the HIPAA Regulations, including but not limited to, Administrator.“Vendor” may also mean an organization acting on behalf of the Recipient conducting data collection solely for the purposes of the Activities and this Data Use Agreement.

## e.“*Recipient*,” means the agency or entity (RAND) that will be receiving the individually identifiable health information either directly or through its Vendor, from staff or personnel from the Covered Entity and/or from Administrator acting on behalf of the Covered Entity**.** Only staff at RAND and/or RAND’s Vendor specifically working on the identified project will have access to individually identifiable information as part of the work they will perform to conduct the data collection.

## f. “*Individually Identifiable Health Information*” means information that is a subset of health information, including demographic information collected from an individual, and;

### (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

### (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

#### a) that identifies the individual; or

#### b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

## g. “*Protected Health Information*”or“*PHI*” means Individually Identifiable Health Information that is transmitted by electronic media; maintained in any medium described in the definition of the term *electronic media* in the HIPAA Regulations; or transmitted or maintained in any other form or medium.

# 2. **Obligations of Covered Entity.**

## a. *Limited Data Set.* Covered Entity agrees that the Protected Health Information as identified in Attachment A to this Agreement (the “*Limited Data Set*”) will be disclosed by either the Covered Entity and/or by Administrator acting on behalf of the Covered Entity to Recipient. The Limited Data Set will exclude the the following identifiers of individuals or of relatives, employers, or household members of individuals: names; postal address information other than town, cities, states, and zip codes; telephone or fax numbers; email addresses, URLs, or IP addresses; social security numbers; medical record numbers; health plan beneficiary numbers; account numbers; certificate or license numbers; vehicle identification or serial numbers (including license plate numbers); device identifiers or serial numbers; biometric identifiers (such as voice and fingerprints); and full face photographs or comparable images

*b. Right to Share.* Notwithstanding any statement to the contrary, Covered Entity represents that it has full authority to share the Limited Data Set with Recipient and has confirmed that the Activities are consistent with such consents or authorizations, if any, as Provider has obtained from individuals who are the subjects of the Limited Data Set.

*c. Data Ownership.* Covered Entity shall retain ownership of any rights it may have in the Limited Data Set, and Recipient does not obtain any rights in the Limited Data Set other than as set forth in this Agreement.

# 3. **Obligations of Recipient.**

## a. *Performance of Activities.* Recipient may use and disclose the Limited Data Set only (1) in the performance of the research activities (the “Activities”) as detailed in Attachment B to this Agreement, or (2) subject to the provisions of Section 3.d, as otherwise required by law.

## b. *Nondisclosure.* Recipient shall not use or further disclose the Limited Data Set in a manner that would violate the requirements applicable to Covered Entity under 45 CFR Sec. 164.514.

## c. *Use or Disclosure as if Covered Entity.* Recipient may not use or disclose the Limited Data Set in any manner that would violate the requirements of HIPAA or the HIPAA Regulations if Recipient were a Covered Entity.

## d. *Disclosures Required by Law.* Recipient shall not, without the prior written consent of Covered Entity, disclose the Limited Data Set on the basis that such disclosure is required by law without notifying Covered Entity so that Covered Entity shall have an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, Recipient shall refrain from disclosing the Data Set until Covered Entity has exhausted all alternatives for relief.

## e. *Safeguards.* Recipient shall use any and all appropriate safeguards sufficient to meet the standards of 45 CFR Sec. 164.530(c) to limit incidental, and avoid prohibited uses and disclosure of the Limited Data Set, and to ensure that only Authorized Persons have access to this Data.

## f. *Recipient’s Agents.* Recipient shall ensure that any agents, including subcontractors, to whom it provides the Limited Data Set agree in writing to be bound by the same restrictions and conditions that apply to Recipient with respect to such Limited Data Set.

## g. *No Identification or Contact.* Recipient shall not use the Limited Data Set, alone or in combination with other information, to identify or contact any individual whose Individually Identifiable Health Information appears in the Limited Data Set.

## h. *Reporting.* In the event Recipient becomes aware of any use or disclosure of the Data not provided for by this Agreement, Recipient shall take any appropriate steps to minimize the impact of such unauthorized use or disclosure as soon as practicable and shall notify Covered Entity of such use or disclosure as soon as possible, but no later than 5 business days after discovery of the unauthorized use or disclosure. Recipient shall cooperate with Covered Entity to investigate, correct, and/or mitigate such unauthorized use or disclosure. Recipient acknowledges that Covered Entity may have an obligation to make further notifications as set forth in Subpart D of 45 CFR §164 or under applicable state law and shall cooperate with the Covered Entity to the extent necessary to enable to meet all such obligations.

4. **Contacts.**

a. The following contacts are the respective organizational representatives for reporting any notices or reports of unauthorized Limited Data Set use or disclosure. These designated contacts may be updated by written notice to the other Party.

For Covered Entity: Name

Title

Address, City, State, Zip

Telephone:

Email:

For Administrator: Name

Title

Address, City, State, Zip

Telephone:

Email:

For Recipient: Christopher Whaley

Policy Researcher

The RAND Corporation

PO Box 2138, Santa Monica, CA 90407-2138

Telephone: 310.393.0411

Email: [cwhaley@rand.org](mailto:cwhaley@rand.org)

With a cc to: [ContractsTeam@rand.org](mailto:ContractsTeam@rand.org)

# 5. **Material Breach, Enforcement and Termination.**

## a. *Term.* This Agreement shall be effective as of the Agreement Effective Date, and shall continue through July 1, 2023, unless the Agreement is terminated earlier in accordance with the provisions of Section 5.c or 5.d. Should the Recipient desire to keep the Limited Data Set for a longer period, a justification in writing should be made to the Covered Entity and/or Administrator.

## b. *Rights of Access and Inspection.* From time to time upon reasonable notice, or upon a reasonable determination by Covered Entity that Recipient has breached this Agreement, Covered Entity may inspect the facilities, systems, books, and records of Recipient to monitor compliance with this Agreement. The fact that Covered Entity inspects, or fails to inspect, or has the right to inspect, Recipient’s facilities, systems, and procedures does not relieve Recipient of its responsibility to comply with this Agreement, nor does Covered Entity’s (1) failure to detect or (2) detection of, but failure to notify Recipient or require Recipient’s remediation of, any unsatisfactory practices constitute acceptance of such practice or a waiver of Covered Entity’s enforcement or termination rights under this Agreement. The Parties’ respective rights and obligations under this Section 5.b shall survive termination of the Agreement.

## c. *Termination by Recipient*. Recipient may terminate this Agreement (1) at any time by notifying the Covered Entity and Administrator and returning or destroying the Limited Data Set in accordance with Section 5.h, or (2) pursuant to Section 6.b of this Agreement.

## d. Covered Entity may terminate this Agreement:

### (1) immediately if Recipient is named as a defendant in a criminal proceeding for a violation of HIPAA or the HIPAA Regulations;

### (2) immediately if a finding or stipulation that Recipient has violated any standard or requirement of HIPAA, the HIPAA Regulations, or any other security or privacy laws is made in any administrative or civil proceeding in which Recipient has been joined; or

### (3) pursuant to Sections 5.e.(3) or 6.b of this Agreement.

## e. *Remedies*. If Covered Entity determines that Recipient has breached or violated a material term of this Agreement, Covered Entity may, at their option, pursue any and all of the following remedies:

### (1) exercise any of its rights of access and inspection under Section 5.b of this Agreement;

### (2) take any other reasonable steps that Covered Entity, in their sole discretion, shall deem necessary to cure such breach or end such violation; and/or

### (3) terminate this Agreement if Recipient has failed to cure any such breach or violation within thirty (30) days of receiving notification by Covered Entity of such breach or violation.

## f.

## g. *Reporting to United States Department of Health and Human Services*. If Recipient’s efforts to cure any breach or end any violation are unsuccessful, and if termination of this Agreement is not feasible, Covered Entity shall report Recipient’s breach or violation to the Secretary of the United States Department of Health and Human Services, and Recipient agrees that it shall not have or make any claim(s), whether at law, in equity, or under this Agreement, against Covered Entity with respect to such report(s).

## h. *Return or Destruction of Records.* Upon termination of this Agreement for any reason, Recipient shall return or destroy, as specified by Covered Entity, the Limited Data Set that Recipient still maintains in any form, and shall retain no copies of such Limited Data Set. Recipient may retain a fully deidentified extract of the Limited Data Set (though not the Limited Data Set itself) for up to five years beyond the termination of this agreement, though the fully deidentified extract may not be shared with any outside entities, and such extract may only be used for research Activities that is reviewed and approved through a formal IRB process and is consistent with the process described in step (8) in Attachment B. If Covered Entity, in its sole discretion, requires that Recipient destroy the Limited Data Set, Recipient shall certify to Covered Entity that the Limited Data Set has been destroyed. Recipient will destroy all Individually Identifiable Health Information received as part of the Limited Data Set no later than the end date set forth in Section 5.a, unless the Agreement is terminated prior to that date. If return or destruction is not feasible, Recipient shall inform Covered Entity of the reason it is not feasible and shall continue to extend the protections of this Agreement to such Limited Data Set and limit further use and disclosure of such Limited Data Set to those purposes that make the return or destruction of such Limited Data Set infeasible.

## i. *Injunctions*. Recipient agrees that any violation of the provisions of this Agreement may cause irreparable harm to Covered Entity. Accordingly, in addition to any other remedies available to Covered Entity at law, in equity, or under this Agreement, in the event of any violation by Recipient of any of the provisions of this Agreement, or any explicit threat thereof, Covered Entity shall be entitled to an injunction or other decree of specific performance with respect to such violation or explicit threat thereof, without any bond or other security being required and without the necessity of demonstrating actual damages. The Parties’ respective rights and obligations under this Section 5.i shall survive termination of the Agreement.

## j. *Indemnification.* Recipient shall indemnify, hold harmless, and defend Covered Entity from and against any and all claims, losses, liabilities, costs, and other expenses directly resulting from, or solely relating to, the gross negligence or willful misconduct of Recipient in connection with the representations, duties, and obligations of Recipient under this Agreement. The Parties’ respective rights and obligations under this Section 5.j shall survive termination of the Agreement.

# 6. **Miscellaneous Terms.**

## a. *State Law.* Nothing in this Agreement shall be construed to require Recipient to use or disclose the Limited Data Set without a written authorization from an individual who is a subject of the PHI from which the Limited Data Set was created, or written authorization from any other person, where such authorization would be required under state law for such use or disclosure.

## b. *Amendment.*

## (1) Covered Entity and Recipient agree that amendment of this Agreement may be required to ensure that Covered Entity and Recipient comply with changes in state and federal laws and regulations relating to the privacy, security, and confidentiality of PHI or the Limited Data Set. The Parties agree to negotiate in good faith to amend this Agreement to comport with changes in state or federal law or regulations that materially alter the Parties’ obligations under this Agreement. Provided however, that if the Parties are unable to agree to mutually acceptable amendment(s) by the compliance date of the change in applicable law or regulations, either Recipient or Covered Entity may terminate this Agreement;

## (2) This Agreement reflects the entire Agreement between the Parties with respect to the subject matter hereof and supersedes all prior or contemporaneous agreements, whether oral or written. This Agreement may only be amended in writing, setting forth the full nature of the amendment, and signed by authorized representatives of both Parties. No rights other than those expressly set forth herein are to be implied by the terms of this Agreement.

## c. *No Third Party Beneficiaries.* Nothing express or implied in this Agreement is intended or shall be deemed to confer upon any person other than Covered Entity and Recipient, and their respective successors and assigns, any rights, obligations, remedies, or liabilities.

## d. *Ambiguities*. The Parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with applicable law protecting the privacy, security, and confidentiality of PHI and the Data Set, including, but not limited to, HIPAA and the HIPAA Regulations.

## e. *Primacy.* To the extent that any provisions of this Agreement conflict with the provisions of any other agreement or understanding between the Parties, this Agreement shall control with respect to the subject matter of this Agreement.

f. *Counterparts.* This Agreement may be executed in counterparts, each of which is deemed an original, but all of which together shall constitute one and the same agreement.

**IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement as of the Agreement Effective Date.**

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**Covered Entity Administrator**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Authorized Representative Signature of Authorized Representative**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Title of Authorized Representative Name and Title of Authorized Representative**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Signed Date Signed**

**THE RAND CORPORATION**

**Recipient**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Authorized RAND Representative**

**Linda F. Duffy, Director, Contracts, Grants, and Procurement**

**Name and Title of Authorized RAND Representative**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Signed**

**ATTACHMENT A**

**Data Request for Round 5 of the RAND Hospital Price Transparency Study**

**This Data Request has 4 Sections:**

This page: Key Reminders

Next page: Attachment A - Bullet Summary of Required Variables

After that: Attachment A - Table of All Requested Variables

Lastly: Attachment B - Data Use Information and Authorization

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**List of Key Reminders**

Please **do not** send the following:

* Data for members that are eligible for any Medicare or Medicaid plan, even if they are enrolled in a commercially managed plan
* Social security numbers, patient names, or any personally identifiable information- we are required to immediately destroy data that comes to us with PII
* Data for years prior to 2018. Anything before 2018 will be discarded. For Round 5 of the study, we will focus on the three year time period 1/1/2020 through 12/31/2022.

Data fields, **please include:**

* Plan type code or Medicare/Medicaid eligibility indicator
* Product type code
* Out of Network indicator
* Inpatient data that contains either:
  + Valid ICD procedure codes **or**
  + Valid DRG codes
* APCDs only: Please include a self-insured or fully-insured indicator
* All data must include variable names on the first line or specific column pointers and definitions - Please include data dictionary

File transfers:

* First time data contributors are strongly encouraged to use RAND’s Kiteworks platform to submit data
* Data should be compressed to a max file size of 1 GB (split into as many files as needed for smooth transfer)
* If submitting delimited files, we prefer pipe- or tab- over comma-delimited, unless strings are fully enclosed in quotation marks

**Attachment A:** **Summary of Required Variables**

In the full table (beginning next page), we list all the variables requested for this study. A subset of this list (the below bullets) arethe **absolutely essential** variables. In other words, if any of the following bulleted variables are missing, we cannot use the data at all.

* **Claim ID** - A unique medical claim identifier assigned by claims processor
* **Member ID or “PATIENT IDENTIFIER”**, usually encrypted and assigned by claims processor. This identifier must be unique to each individual member, it must uniquely identify a member throughout the entire submission (i.e. across years). This field must not be an unencrypted social security number.
* **Allowed Amount (or Paid + Deductible + Copay + Coinsurance)** The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for non-contracted providers
* **From and To Date of Service**
* **CPT** – The 5 character code for the medical procedure a patient received from a health care provider. Current coding methods include: CPT-4 and HCFA Common Procedure Coding System Level II - (HCPCS-II).
* **Place of Service (POS)** - Identify the setting, using a place of service code, for each item used or service performed. Usually this is a 2 digit numeric code as described here: <https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set>

This variable is sometimes named “**CMS place of service**” or “**facility type**”.

* **Bill type** – Field 4 of the UB-04 Type of Bill
* **Diagnosis code(s)** – Primary and other ICD-10 diagnosis codes
* **Servicing NPI or TIN** - The National Provider Identifier (NPI) assigned to the Rendering Provider. This is the lowest level of provider available (for example, if both individual and group are available, then the individual should be provided). Federal tax identification number (TIN) or employer identification number (EIN) of the provider may also be used. TIN may be omitted if the claim is a professional claim and the provider has indicated that the TIN is an SSN. We would prefer to have both the billing and servicing NPI, and both the billing and servicing TIN, but we must have at least 1.
* **ICD procedure code(s)** - Primary and other ICD-10 procedure codes
* **Revenue code** – The 4 character code used on the UB-92 (Form Locator 42) to identify a specific accommodation, ancillary service, or billing calculation related to the service being billed. The code can identify the cost center in the institution where inpatient care was provided, for example: physical therapy, surgery, room and board.
* **Patient’s Age or Date of Birth** -- Exact DOB not necessary, can be year of birth at a minimum.
* **Patient Sex**
* **Patient Discharge Status** – The hospital discharge status code
* Both **Facility and Professional Claims**

**Billed Amount** (aka **Total Charges**, Field 47 of UB-04, CMS-1500 Item 24F) and **Out of Network Indicator** are also extremely helpful (but not absolutely required).

**Attachment A: Complete List of Requested Data Fields**

| **COLUMN NAME** | ***Column Description*** | ***Notes*** | ***Considered PHI? (blank = no) (if yes, this field will be processed and removed in first step in processing)*** | ***UB-04 field (if applicable)*** | ***CMS-1500 item (if applicable)*** |
| --- | --- | --- | --- | --- | --- |
| Claim ID | *A unique medical claim identifier.* | *Assigned by claims processor* |  |  |  |
| Type of claim | *Indicator for facility claim or professional claim. Facility claims are submitted using the UB-04 layout, professional claims are submitted using the CMS-1500 layout.* | *Assigned by claims processor* |  |  |  |
| Servicing Provider Name | *Either the concatenated Individual Provider First and Last Name of the servicing provider (for professional claims) or the Provider Organization Full Name of the servicing provider (for facility claims)* |  |  | *Field 1* | *Item 32* |
| Servicing Provider Street Address | *Street address of the servicing provider* |  |  | *Field 1* | *Item 32* |
| Servicing Provider City | *City of the servicing provider* |  |  | *Field 1* | *Item 32* |
| Servicing Provider State | *State of the servicing provider (2-character postal abbreviation)* |  |  | *Field 1* | *Item 32* |
| Servicing Provider Zip | *Zip code of the servicing provider* |  |  | *Field 1* | *Item 32* |
| Billing Provider Name | *Either the concatenated Individual Provider First and Last Name of the billing provider (for professional claims) or the Provider Organization Full Name of the billing provider (for facility claims)* |  |  | *Field 2* | *Item 33* |
| Billing Provider Address | *Street address of the billing provider* |  |  | *Field 2* | *Item 33* |
| Billing Provider City | *City of the billing provider* |  |  | *Field 2* | *Item 33* |
| Billing Provider State | *State of the billing provider (2-character postal abbreviation)* |  |  | *Field 2* | *Item 33* |
| Billing Provider Zip | *Zip code of the billing provider* |  |  | *Field 2* | *Item 33* |
| UB04 Type of bill | *Only available for facility claims. TYPE OF BILL CODE is a four-digit alphanumeric code that gives three specific pieces of information after a leading zero. CMS will ignore the leading zero. CMS will continue to process three specific pieces of information. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.* |  |  | *Field 4* |  |
| TIN | *Federal tax identification number (TIN)/employer identification number (EIN) of provider* | *Omit if the claim is a professional claim and the provider has indicated that the TIN is an SSN* |  | *Field 5* | *Item 25* |
| Statement covers period from date | *CLAIM STATEMENT FROM DATE represents the earliest date of service of the claim.* |  | *yes* | *Field 6* |  |
| Statement covers period through date | *CLAIM STATEMENT TO DATE represents the last date of service of the claim* |  | *yes* | *Field 6* |  |
| Pay-to ID | *PROVIDER IDENTIFIER assigned by claims processor* | *If claims processor has a billing provider ID (other than NPI or TIN), then please include here.* |  |  |  |
| Patient identifier (encrypted) | *PATIENT IDENTIFIER assigned by claims processor* |  |  |  |  |
| Medicare Eligibility Indicator | *Indicates if the member was eligible for Medicare at the time of service* | *Assigned by claims processor* |  |  |  |
| Patient birth date | *SOURCE MEMBER BIRTH DATE is the date the Member was born, as it exists in the system of record.* |  | *yes* | *Field 10* | *Item 3* |
| Patient sex | *SOURCE MEMBER GENDER CODE is a code which defines the gender / sex of an individual, as it exists in the System of Record.* |  |  | *Field 11* | *Item 3* |
| Admission date | *ADMIT DATE is the date the member was admitted to an inpatient facility.* |  | *yes* | *Field 12* |  |
| Discharge date | *DISCHARGE DATE is the date the member was released from an inpatient facility.* |  | *yes* |  |  |
| Start date of related hospitalization | *From date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.* |  | *yes* |  | *Item 18* |
| End date of related hospitalization | *To date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.* |  | *yes* |  | *Item 18* |
| Type of admission/visit | *ADMISSION TYPE CODE represents the priority of the admission, such as, emergency, urgent, elective or newborn.* |  |  | *Field 14* |  |
| Source of admission | *ADMISSION SOURCE CODE represents the point of patient origin for this admission or visit.* |  |  | *Field 15* |  |
| Patient Discharge Status | *DISCHARGE STATUS CODE represents the hospital discharge status code.* |  |  | *Field 17* |  |
| Line number | *The line item number for a service in a claim* |  |  |  |  |
| From date of service | *Date of service, from date* |  | *yes* |  | *Item 24A* |
| To date of service | *Date of service, to date* |  | *yes* |  | *Item 24A* |
| Place of service | *Identify the setting, using a place of service code, for each item used or service performed.* |  |  |  | *Item 24B* |
| Revenue code | *Industry Standard - Code used on the UB-92 (Form Locator 42) to identify a specific accommodation, ancillary service, or billing calculation related to the service being billed. The code can identify the cost center in the institution where inpatient care was provided, for example: physical therapy, surgery, room and board.* | *Four characters* |  | *Field 42* |  |
| HCPCS/CPT code | *Industry Standard - Medical procedure a patient received from a health care provider. Current coding methods include: CPT-4 and HCFA Common Procedure Coding System Level II - (HCPCS-II).* | *Five characters* |  | *Field 44* | *Item 24D* |
| HCPCS/CPT modifier 1 | *Indicates special circumstances related to the performance of the service. For example, the 5 digit HCPCS base code if followed by 80 would indicate that an assistant surgeon delivered that service* | *Two characters* |  | *Field 44* | *Item 24D* |
| HCPCS/CPT modifier 2 | *Indicates special circumstances related to the performance of the service. For example, the 5 digit HCPCS base code if followed by 80 would indicate that an assistant surgeon delivered that service* | *Two characters* |  | *Field 44* | *Item 24D* |
| HCPCS/CPT modifier 3 | *Indicates special circumstances related to the performance of the service. For example, the 5 digit HCPCS base code if followed by 80 would indicate that an assistant surgeon delivered that service* | *Two characters* |  | *Field 44* | *Item 24D* |
| HCPCS/CPT modifier 4 | *Indicates special circumstances related to the performance of the service. For example, the 5 digit HCPCS base code if followed by 80 would indicate that an assistant surgeon delivered that service* | *Two characters* |  | *Field 44* | *Item 24D* |
| Billed Service units | *Service count, as billed. Generally, the entries in this column quantify services by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.* |  |  | *Field 46* |  |
| Paid Service units | *Service count, paid, generated by claims processor* |  |  |  |  |
| Days or units | *This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.* |  |  |  | *Item 24G* |
| Total charges | *Total charges* |  |  | *Field 47* | *Item 24F* |
| Noncovered charges | *The portion of the cost of this service that was deemed not eligible by the insurer because the service or member was not covered by the subscriber contract* |  |  | *Field 48* |  |
| Rendering NPI | *Industry Standard - The National Provider Identifier assigned to the Rendering Provider. This is the lowest level of provider available (for example, if both individual and group are available, then the individual should be provided).* |  |  | *Field 56* | *Item 24J* |
| Facility location NPI | *The NPI of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.* |  |  |  | *Item 32A* |
| Billing NPI | *Industry Standard - The National Provider Identifier assigned to the Billing Provider. This may represent a facility (for facility claims), a physician, a rendering provider, a group, or a billing entity.* |  |  |  | *Item 33A* |
| ICD version flag | *Flags ICD diagnoses and procedure codes as ICD-10* |  |  |  |  |
| Principal Diagnosis Code | *PRINCIPAL DIAGNOSIS CODE represents an ICD CM Diagnosis Code identifying a condition being treated. This was replicated to Claim Line for ease of reporting.* | *ICD-10* |  | *Field 67* | *Item 21.1* |
| Other Diagnosis 1 | *OTHER 1 EXTERNAL CAUSE OF INJURY CODE represents an ICD CM Diagnosis Code identifying the External Cause of Injury usually found with other Diagnosis Codes.* | *ICD-10* |  | *Field 67A* | *Item 21.2* |
| Other Diagnosis 2 | *OTHER 2 EXTERNAL CAUSE OF INJURY CODE represents an ICD CM Diagnosis Code identifying the External Cause of Injury usually found with other Diagnosis Codes.* | *ICD-10* |  | *Field 67B* | *Item 21.3* |
| Other Diagnosis 3 | *OTHER 3 EXTERNAL CAUSE OF INJURY CODE represents an ICD CM Diagnosis Code identifying the External Cause of Injury usually found with other Diagnosis Codes.* | *ICD-10* |  | *Field 67C* | *Item 21.4* |
| Other Diagnosis 4 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67D* | *Item 21.5* |
| Other Diagnosis 5 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67E* | *Item 21.6* |
| Other Diagnosis 6 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67F* | *Item 21.7* |
| Other Diagnosis 7 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67G* | *Item 21.8* |
| Other Diagnosis 8 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67H* | *Item 21.9* |
| Other Diagnosis 9 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67I* | *Item 21.10* |
| Other Diagnosis 10 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67J* | *Item 21.11* |
| Other Diagnosis 11 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67K* | *Item 21.12* |
| Other Diagnosis 12 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67L* |  |
| Other Diagnosis 13 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67M* |  |
| Other Diagnosis 14 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67N* |  |
| Other Diagnosis 15 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67O* |  |
| Other Diagnosis 16 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67P* |  |
| Other Diagnosis 17 | *Industry Standard - Additional diagnosis identified for this member. Decimals will be included.* | *ICD-10* |  | *Field 67Q* |  |
| Present on Admission Indicator, Principal Diagnosis | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67* |  |
| Present on Admission Indicator, Other Diagnosis 1 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67A* |  |
| Present on Admission Indicator, Other Diagnosis 2 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67B* |  |
| Present on Admission Indicator, Other Diagnosis 3 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67C* |  |
| Present on Admission Indicator, Other Diagnosis 4 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67D* |  |
| Present on Admission Indicator, Other Diagnosis 5 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67E* |  |
| Present on Admission Indicator, Other Diagnosis 6 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67F* |  |
| Present on Admission Indicator, Other Diagnosis 7 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67G* |  |
| Present on Admission Indicator, Other Diagnosis 8 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67H* |  |
| Present on Admission Indicator, Other Diagnosis 9 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67I* |  |
| Present on Admission Indicator, Other Diagnosis 10 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67J* |  |
| Present on Admission Indicator, Other Diagnosis 11 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67K* |  |
| Present on Admission Indicator, Other Diagnosis 12 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67L* |  |
| Present on Admission Indicator, Other Diagnosis 13 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67M* |  |
| Present on Admission Indicator, Other Diagnosis 14 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67N* |  |
| Present on Admission Indicator, Other Diagnosis 15 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67O* |  |
| Present on Admission Indicator, Other Diagnosis 16 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67P* |  |
| Present on Admission Indicator, Other Diagnosis 17 | *POA indicator* | *Y=yes, N=no, U=unknown, W=undetermined, 1=exempt from POA reporting* |  | *Eighth digit of field 67Q* |  |
| Admitting Diagnosis Code | *ADMITTING DIAGNOSIS CODE represents an International Classification of Diseases (ICD) Diagnosis Code identifying a condition being treated, upon admission.* | *ICD-10* |  | *Field 69* |  |
| Principal procedure code | *Industry Standard - Principal medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74* |  |
| Principal procedure date | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74* |  |
| Other procedure code 1 | *Industry Standard - Other medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74A* |  |
| Other procedure date 1 | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74A* |  |
| Other procedure code 2 | *Industry Standard - Other medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74B* |  |
| Other procedure date 2 | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74B* |  |
| Other procedure code 3 | *Industry Standard - Other medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74C* |  |
| Other procedure date 3 | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74C* |  |
| Other procedure code 4 | *Industry Standard - Other medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74D* |  |
| Other procedure date 4 | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74D* |  |
| Other procedure code 5 | *Industry Standard - Other medical procedure a patient received during inpatient stay.* | *ICD-10* |  | *Field 74E* |  |
| Other procedure date 5 | *Represents the date that the corresponding procedure was performed.* |  | *yes* | *Field 74E* |  |
| Claim status (paid as primary/paid as secondary/paid as tertiary/reversed/denied) | *CLAIM DISPOSITION CODE identifies the type of claim, whether an original, reversal, adjustment or void.* |  |  |  |  |
| In-network provider flag | *Flag for whether the health plan has a network contract with service provider* | *Yes/No* |  |  |  |
| In-network cost sharing flag | *Flag for whether the claim was paid applying in-network benefits to determine the patient's cost sharing* | *Yes/No* |  |  |  |
| MS-DRG code | *DIAGNOSIS RELATED GROUP CODE represents the specific 'Diagnosis Related Group' (DRG) associated with a Claim. A DRG is a national coding scheme which classifies an inpatient stay based on diagnosis, procedure, discharge status, age and sex.* |  |  |  |  |
| MS-DRG version | *DIAGNOSIS RELATED GROUP VERSION NUMBER represents the version of the vendor Diagnosis Related Group (DRG) table.* | *If available, please supply here the rate year corresponding to the MS-DRG code. If not available, ok to omit. If omitted, RAND will assume that MS-DRG codes are assigned applying appropriate MS-DRG grouper based on federal fiscal year of date of discharge.* |  |  |  |
| Allowed amount | *Measure - The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for non-contracted providers.* |  |  |  |  |
| Paid amount | *Measure - The amount sent to the payee from the health plan. This amount is to include withhold amounts (the portion of the claim that is deducted and withheld by the Plan from the provider's payment) and exclude any member cost sharing.* |  |  |  |  |
| Deductible amount | *Measure - The portion of this service that the member must pay which is applied to the total period deductible. Deductibles are usually applied over a specific time period, such as per calendar year, per benefit period, or per episode of illness. Amounts should include any sanction/penalty or deductible form of insured non-compliance such as lack of prior authorizations.* |  |  |  |  |
| Coinsurance amount | *Measure - The amount the insured individual pays, as a set percentage of the cost of covered medical services, as an out-of-pocket payment to the provider. Example: Insured pays 20% and the insurer pays 80%. This amount should include member sanctions/penalties for out of network or any coinsurance form of insured non-compliance such as lack of prior authorizations.* |  |  |  |  |
| Copay amount | *Measure - Amount an insured individual pays directly to a provider at the time the services or supplies are rendered. Usually, a copay will be a fixed amount per service, such as $15.00 per office visit. Amounts should include any sanction/penalty or copay form of insured non-compliance such as lack of prior authorizations.* |  |  |  |  |
| COB amount | *An amount paid through coordination of benefits* |  |  |  |  |
| Capitated payment flag (is this an information-only claim submitted by a provider who receives a capitated payment) | *CAPITATION GROUP INDICATOR CODE is a Yes / No code used to identify a paid claim for a group with a capitated arrangement* |  |  |  |  |
| Prepaid amount | *For capitated services, the fee for service equivalent amount.* |  |  |  |  |
| Plan type code | *Type of plan, including categories that identify Medicare Advantage or managed Medicaid plans* |  |  |  |  |
| Product type code | *Type of insurance coverage that a member is enrolled in* |  |  |  |  |
| Self-insured indicator or employer account number | *Account number uniquely identifies the account ID of the self-insured employer* | *Can be an indicator of a self-insured plan rather than an account number* |  |  |  |
| Out of Network Indicator |  |  |  |  |  |
| Fully insured indicator or line of business | *Insurance product type (large group, small group, individual market) – This variable is Required for APCDs only.* | *Can be an indicator of a fully insured plan rather than line of business* |  |  |  |

**ATTACHMENT B**

DATA USE INFORMATION AND AUTHORIZATION

**Institutional Review Board (IRB) review**.

☒ RAND will be reviewed through a formal IRB process.

☐ RAND has received approval through a formal IRB process.

☐ The IRB has approved waiver of individual authorization. If checked, see enclosed approval.

☐ IRB review not required. [*Add explanation.*]

**Access to Project Data by External Entities.**

No entities other than RAND will be given nor will have access to project data.

**Authorized Data Usage (Project)**.

PROJECT DESCRIPTION

Large employers typically offer health benefits to their employees through a “self-insured” plan, meaning the employer pays their employees’ claims and bears financial risk. Those employers are repeat buyers of health care services, which could put them in a strong position to demand increased value from the health care system. However, they rely on health plans and other intermediaries to negotiate contracts with providers and to process claims, and they generally lack useful information on the prices they are paying. The lack of transparency in contracting and negotiated prices undermines the ability of self-insured employers to demand value.

The Employers’ Forum of Indiana (EFI) is a multistakeholder, employer-led coalition whose mission is “to improve the value payers and patients receive for their health care expenditures.” EFI serves mainly in a convening role, and does not have the resources to fund significant research efforts on its own.

On November 8, 2016, RAND and EFI entered into a memorandum of understanding (MOU) describing a research project titled "Hospital Price Transparency Pilot" (the "pilot", or "round 1.0"). To conduct the pilot, RAND received funding from the Robert Wood Johnson Foundation (RWJF) and received hospital claims data from self-insured employer members of EFI. In September 2017, RAND published a research report titled "Hospital Prices in Indiana: Findings from an Employer-Led Transparency Initiative" ( <https://www.rand.org/pubs/research_reports/RR2106.html> ) that contained the results of the pilot. The pilot illustrated for employer members of EFI and for other employers and employer groups nationwide, a feasible and replicable approach to measuring and comparing hospital prices.

RAND and EFI continued to collaborate on follow-on projects titled "National Hospital Price Transparency Study” (Rounds 2, 3, and 4). The goals of rounds 2, 3, and 4 of the study were to prepare and disseminate broadly a public hospital price report based on claims data from three types of data contributors:

• Self-insured employers and coalitions of self-insured employers, including members of EFI as well as employers and coalitions based outside Indiana;

• fully insured health plans; and

• all-payer claims databases.

Round 2 covered 2014-2016 and results were published on May 9, 2018 at: <https://www.rand.org/pubs/research_reports/RR3033.html>

Round 3 covered 2016-2018 and results were published on September 17, 2020 at: <https://www.rand.org/pubs/research_reports/RR4394.html>

Round 4 covered 2018-2020 were published on May 17, 2022 at:

<https://www.rand.org/pubs/research_reports/RRA1144-1.html>

Round 5 will cover 2020-2022 and RAND plans to publish results during 2024.

One of the key goals of each successive Round has been to broaden the pool of data contributors to allow public reporting of prices for a broader set of hospitals, including hospitals outside Indiana. A second key goal was to shift the funding for the study to a more-sustainable model that includes foundation funding plus funding from self-insured employers. Each self-insured employer that contributes data and funding for the National Study receives a private employer-specific price report.

The key intended audiences for the reports are 1) large self-insured employers including members of EFI and other employer business coalition across the country, 2) intermediaries responsible for negotiating prices with hospitals, and 3) policy makers and researchers who are interested in price transparency. The Round 2 study focused on unit prices for hospital services because they have been identified in previous research as a key contributor to recent growth in spending per capita among the privately insured, and a key driver of geographic variation in spending among the privately insured. The public final report for Round 2 describes the project’s background and analytic methods, and includes measures of negotiated prices paid to specific, named facilities. That level of specificity will allow employers to assess whether negotiated prices for hospital care are in line with the quality and value of the services provided by those hospitals or health systems. Two measures of negotiated prices were calculated and reported publicly in the Round 2 report. The first price measure is relative prices (meaning allowed amounts) as a percent of the amount that Medicare would have paid to the same facilities for the same services. Medicare provides a useful price benchmark for three reasons. First, Medicare is the largest purchaser of health care services in the world and in many ways the standard setter in the U.S. health care system. Second, Medicare prices are set with the overarching goal of compensating providers fairly based on the costs of doing business and the services they provide. Third, Medicare makes detailed price data freely and publicly available. The second price measure is dollars per casemix-adjusted unit of service. For inpatient hospital stays casemix adjustment is based on Medicare Severity Diagnosis Related Groups (MS-DRGs), and for outpatient visits casemix adjustment is based on the Medicare Ambulatory Payment Classification (APC) system. The second price measure differs from the first in that it does not include Medicare's adjustments for local wages or hospital characteristics (e.g. teaching).

RAND and EFI’s Round 5 of the study differs from previous rounds in that the pool of data contributors will continue to expand to include additional self-insured employers, additional APCDs, and additional health plans in all 50 United States. The claims data includes both facility and professional claims, so that relative and standardized prices could be calculated for services that include a facility fee and a professional fee. The types of facilities included in the analysis have been expanded to include not just Medicare-certified short-stay hospitals but also other types of facilities, such as children's hospitals, cancer hospitals, and ambulatory surgical centers.

For each self-insured employer that contributed data and funding, RAND prepares an employer-specific price report that includes price measures based just on claims data from that employer. The employer-specific price reports allow employers to compare the negotiated prices paid by their health plan with the average prices paid by all health plans that contributed data to the study.

The ongoing Round 5 of this study will continue to expand data collection from all 50 United States. As more employers and TPAs contribute data, its value increases to all involved, including policymakers.

Especially during the COVID-19 pandemic, many self-insured employers are struggling with health care costs, and any additional information on prices could help them to manage their plans. Ultimately, the goal of Round 5 is to help those employers to become better informed, and to advocate more effectively on their employees’ behalf for increasing value in the health care system.

Project Technical Approach. The analysis will follow these steps:

(1) RAND will enter into appropriate Data Use Agreements (DUAs) with each of the data suppliers. These agreements, which are required by the Health Insurance Portability and Accountability Act (HIPAA) privacy rule, will establish appropriate safeguards so that RAND may receive protected health information in the form of a HIPAA Limited Data Set and guarantee that it will be maintained securely.

(2) Participating self-insured employers will instruct their claims administrator to provide RAND with facility and professional claims data. These claims data will span at least the period from January 1, 2020 through December 31, 2022. (Data contributors have the option to also submit claims as far back as 1/1/2018, but no earlier than that.) These claims data will identify the provider, the specific service provided (including Healthcare Common Procedure Coding System [HCPCS] codes, ICD-10 diagnoses and procedures, and charge data by cost center), submitted charges, and allowed amounts. (See Attachment A for a complete list of variables needed for the study.)

(3) RAND will attach Medicare provider numbers and health system identifiers to each claim. RAND will identify claims for services provided by Medicare-certified short-stay hospitals and other types of facilities, such as children's hospitals, cancer hospitals, and ambulatory surgical centers.

(4) RAND will use publicly available “grouper” software from the Centers for Medicare & Medicaid Services (e.g., https://downloads.cms.gov/files/MS-DRG-MCE-Software-2017.zip) to assign casemix classification codes to each claim. For inpatient stays, the Medicare Severity Diagnosis Related Grouper (MS-DRG) software will be used. For outpatient visits, the Ambulatory Payment Classification (APC) software will be used.

(5) RAND will compile the claims data and prepare a detailed price report that includes the two price measures, the first being the average allowed amount paid relative to a Medicare benchmark, and the second being allowed amounts per casemix-adjusted unit of service. In addition, relative price variation and price trends will be noted for large health systems. In order to guarantee enrollee confidentiality, this public price report will only include facilities with 11 or more claims.

(6) RAND will prepare a public final report that includes summary price measures for each hospital with 11 or more claims. This public report will describe the patterns observed in the price data, specify the analytic methods, and summarize the key takeaways for health plan administrators and policy makers.

(7) RAND will prepare a set of employer-specific price reports that include price measures from the public report plus price measures based just on claims data from each self-insured employer. RAND will **not** publish the employer-specific price reports, and will send each private report directly to the self-insured employer that contributed to funding this study.

(8) RAND and EFI, in consultation with self-insured employers who are participating in the study, will identify research topics of interest to those employers, and RAND will conduct and disseminate the results of that research. For example, in some areas of the country privately insured patients visiting an emergency department are at high risk of receiving a "surprise bill" from an out-of-network professional. One likely follow-on study would be an examination of the share of emergency department visits that include professional services provided by an out-of-network provider.

EFI will assist RAND with identifying and recruiting participants for Round 5, and EFI and RAND will communicate throughout the project. Data suppliers will communicate with RAND to establish DUAs and other agreements as needed.