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HEALTH CARE: PRICE TRANSPARENCY AND NO SURPRISES

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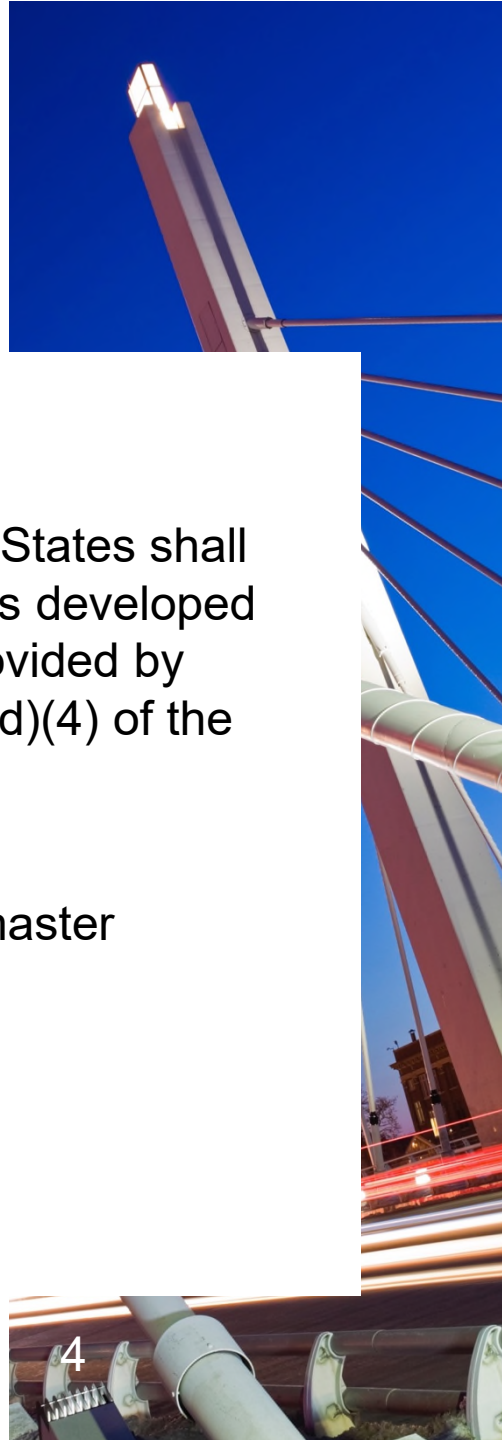
Agenda

- Reviewing new federal rules providing transparency in hospital and health care pricing
  - Hospital Price Transparency
    - Applicable to hospitals
  - Transparency in Coverage
    - Applicable to Group Health Plans and Health Insurers
  - No Surprises Act
    - Regulates Emergency Air Ambulance and Certain Out-of-Network (OON) services
    - Precludes Balance Billing in Certain Situations
    - Independent Dispute Resolution Provisions
    - Provision of Good Faith Estimates for Uninsured

Hospital Price Transparency Rule

- Effective January 1, 2021 (part of 45 CFR Section 180)
- Statutory authority is Public Health Service Act, Section 2718(e) (part of ACA)
- Applies to “hospitals”

Background



Section 2718(e) of the PHS Act provides

- (e) STANDARD HOSPITAL CHARGES – Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act
- "Standard charges" is not defined in the PHS Act
- Prior HHS guidance from 2015 defined "standard charge" as the hospital's chargemaster charge (79 FR 501446)

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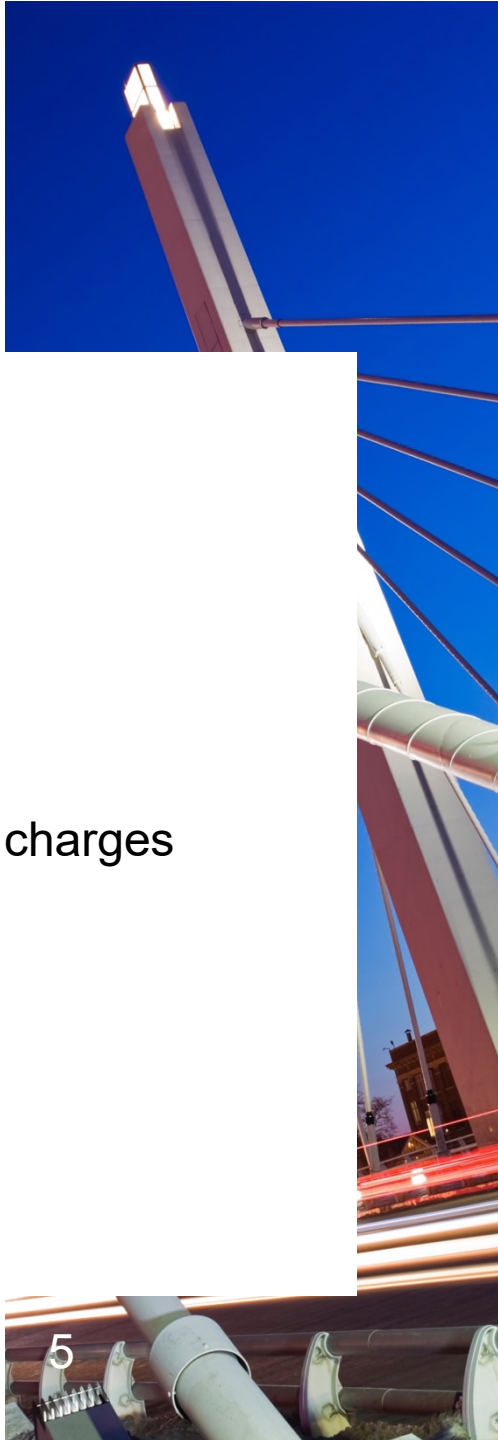
Background (cont'd)



Purposes and Goals of Hospital Price Transparency Rule

- Assist patients in knowing the prices and quality of health care goods and services
- Help patients make informed choices
- Lead to reduction in health care costs
- Fix "opaque" pricing structures
- Provide information on price that will protect patients from surprise billing and excessive charges

What Does the Rule Cover and Require?

Key Provisions of Rule

- Definition of “hospital” to which the Rule applies
- Meaning of “standard charges”
- Meaning of “items and services” provided by hospital
- “Shoppable services” requirement
- Enforcement, appeal and penalties

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“Hospitals” Under the Rule

- The term “hospital” as used in the Rule
  - Hospitals licensed by a state (including D.C. and territories)
  - Not limited to Medicare and Medicaid participating hospitals
  - Exemptions for federally owned and operated facilities – VA Medical Centers, Indian health operated facilities, Department of Defense operated hospitals
  - Includes CAHs, rural health centers, and LTACHs, if licensed as a hospital

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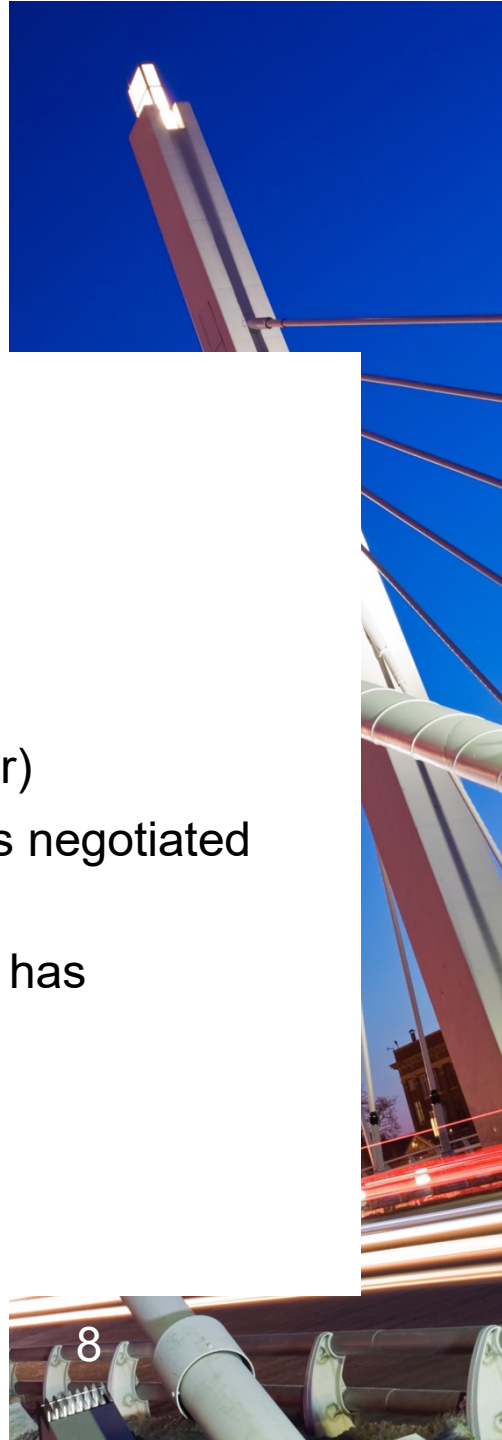
“Standard Charges” Under the Rule



Broad definition of “Standard Charges”

Standard Charges in the Rule includes 5 categories

(1) The discounted cash price (price applied to individual who pays cash)

(2) The gross charges of the hospital (from the chargemaster)

(3) The payer-specified negotiated charges (charge negotiated with a third-party payer)

(4) The de-identified minimum negotiated charges (lowest charge that the hospital has negotiated with all third-party payers for an item or service)

(5) The de-identified maximum negotiated charges (the highest charge that a hospital has negotiated with all third-party payers for an item or service)

[Medicare FFS and Medicaid rates are not “negotiated,” so not covered. Medicare Advantage charges must be included]

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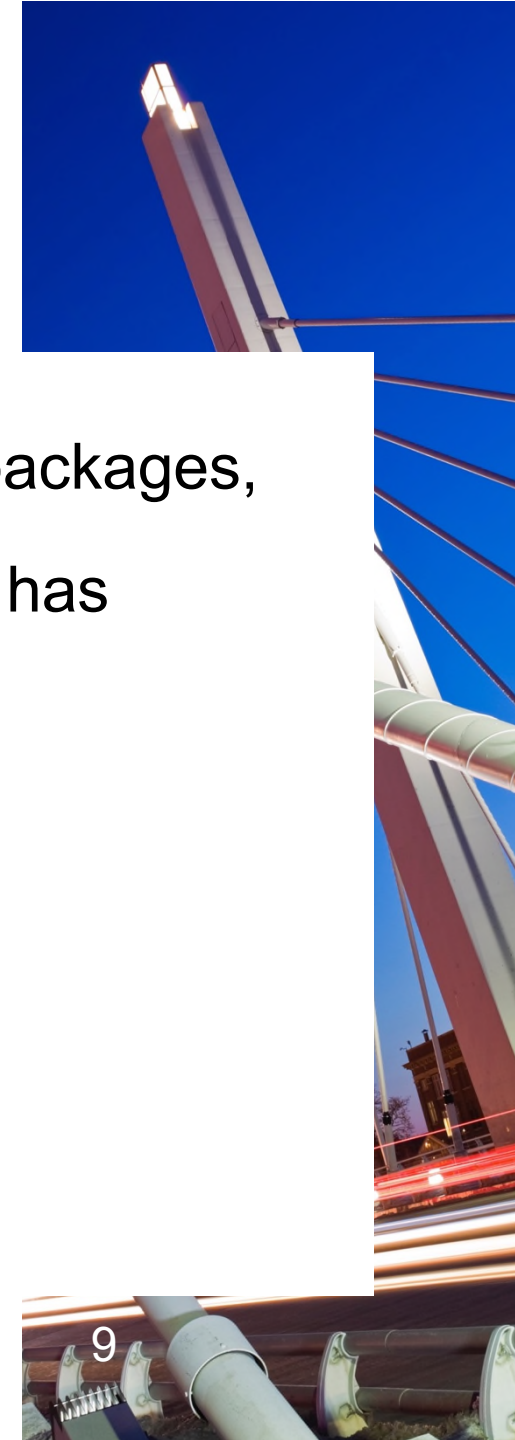
Hospital Items or Services

- All items and services, including items and services and service packages, that could be provided to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a standard charge

  Includes
  - Supplies and procedures
  - Room and board
  - Facility fees
  - Service packages
  - Services of hospital employed physicians and non-physician practitioners
  - Anything else for which hospital has established a Standard Charge



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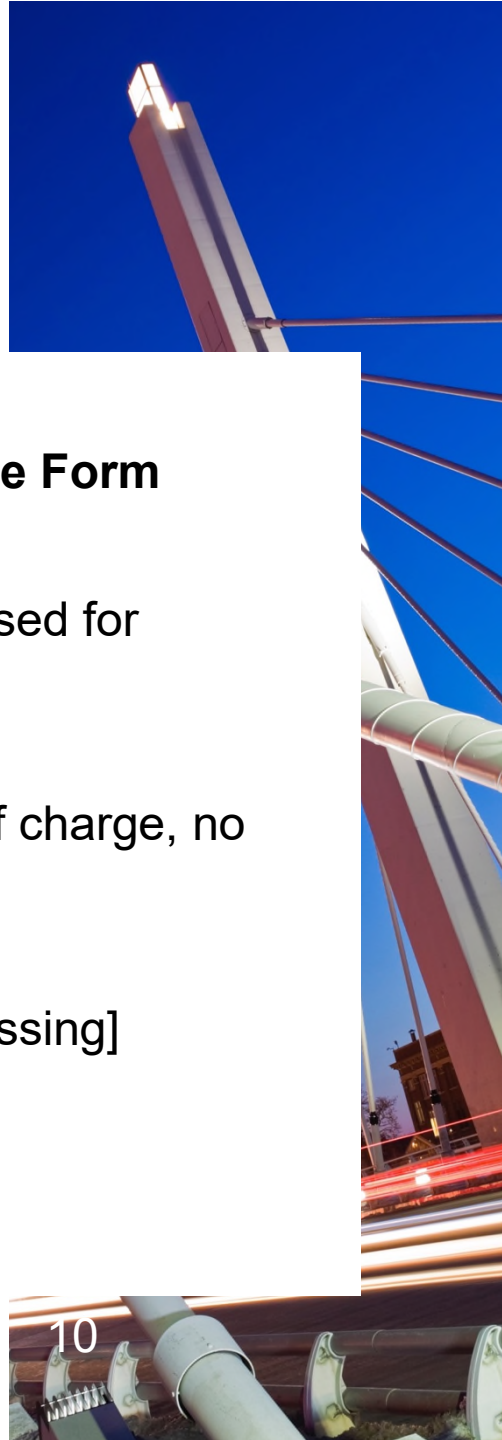
First Requirement of Rule



- **Make public all Standard Charges for all Items and Services in a Machine-Readable Form**
- Applies to each hospital location
- Must include a description of each Item or Service (including packages) and any code used for accounting or billing
- Single file containing all 5 types of Standard Charges
- Display file prominently on hospital website and be easily accessible (no barriers, free of charge, no password and searchable)
- Must update annually, including date of last update

[.XML, .JSON and .CSV formats okay; PDF not okay as not easily extracted without processing]

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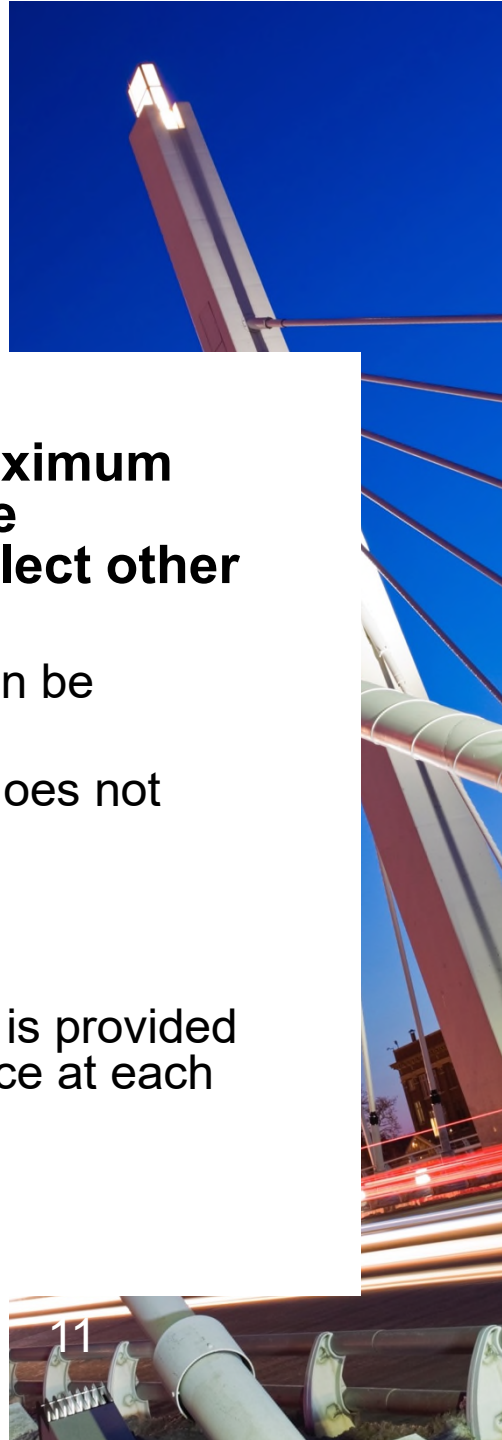
Second Requirement: Shoppable Services



- **Hospitals must list payer-specific charges, de-identified minimum and maximum negotiated charges and discounted cash prices for at least 300 Shoppable Services, including 70 CMS-specific Shoppable Services (hospital may select other 230), in a consumer friendly form**
  - "Shoppable Services" are services that are commonly provided by the hospital and can be scheduled in advance
  - If hospital does not provide one of the 70 services identified by CMS must indicate it does not offer the service and select a replacement so that 300 are listed
  - If hospital offers less than 300 Shoppable Services, must list all that it provides
- For each Shoppable Service, the hospital is required to
  - Include a plain language description of each service, the location at which the service is provided (and whether inpatient or outpatient) and the required charge information for the service at each location

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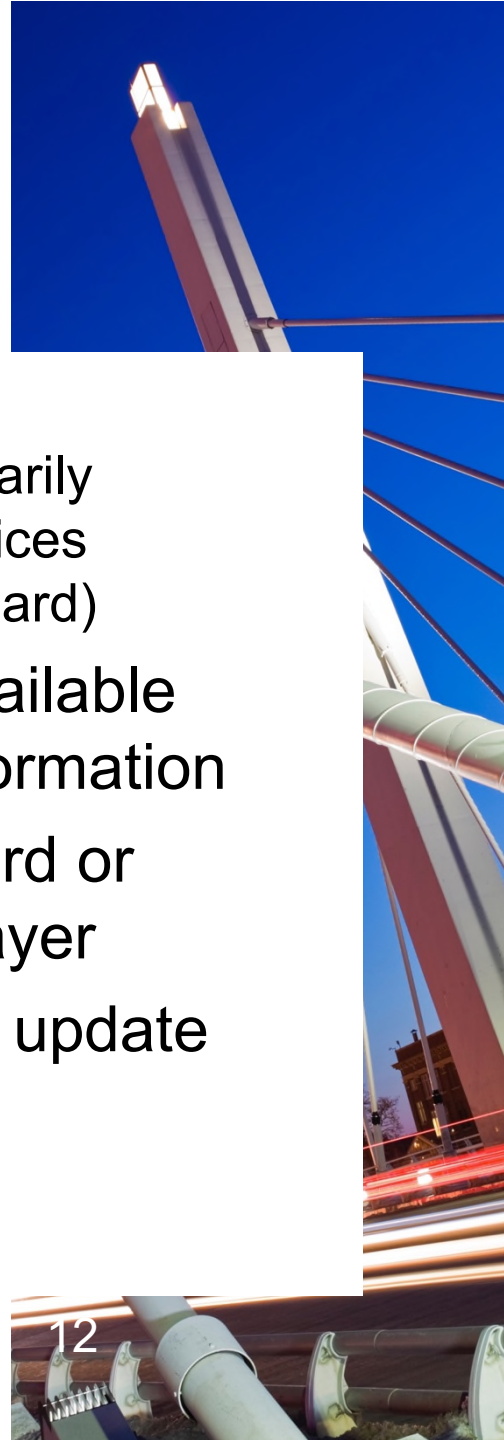
Second Requirement: Shoppable Services (cont'd)



  - Group the Shoppable Service with ancillary services that the hospital customarily provides in conjunction with such primary Shoppable Services (ancillary services include lab, radiology, drugs, therapies, employed pro. services, room and board)
- Display information in a consumer-friendly format on a publicly-available internet location that clearly identifies the service and required information
- Ensure easy accessibility – no barriers, free of charge, no password or registration, searchable by service description, billing code and payer
- Update the information at least annually and include date of latest update

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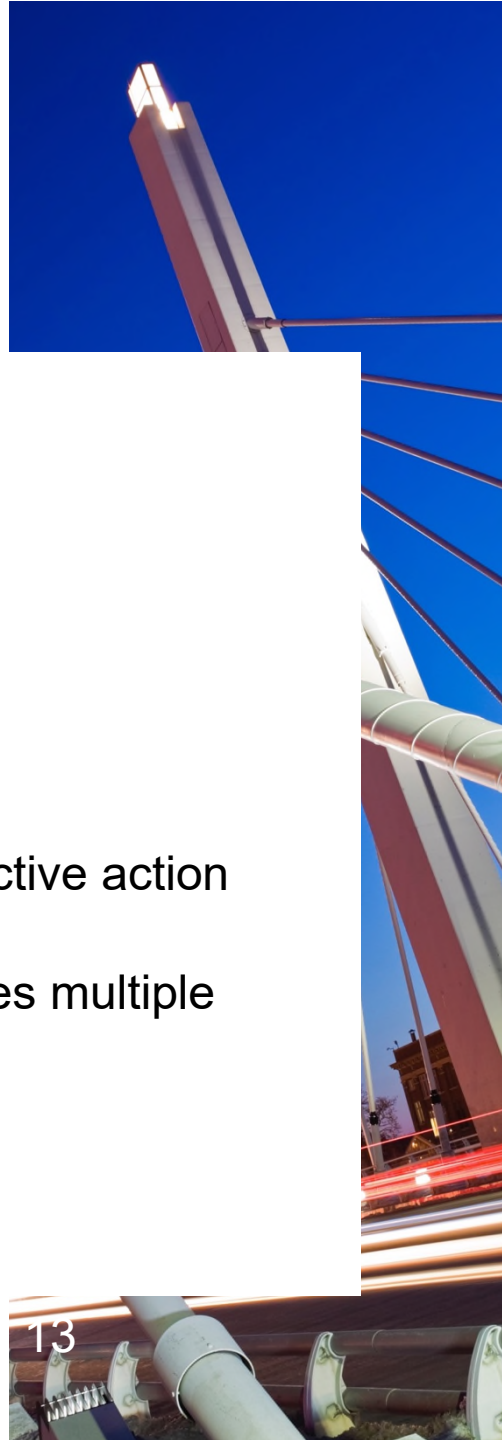
Monitoring and Enforcement



- CMS will monitor hospital compliance by the following
  - Complaints from individuals or entities
  - Audit of hospitals' websites
- If noncompliance found
  - Written warning
  - Request corrective action plan
  - Impose a CMP on hospital and publicize non-compliance if hospital fails to do a corrective action plan
- Initially maximum CMP per day of non-compliance was $300/day (even if hospital violates multiple discrete requirements)
- Widespread non-compliance
- Penalties increased for 2022, includes multiplier based on size of hospital

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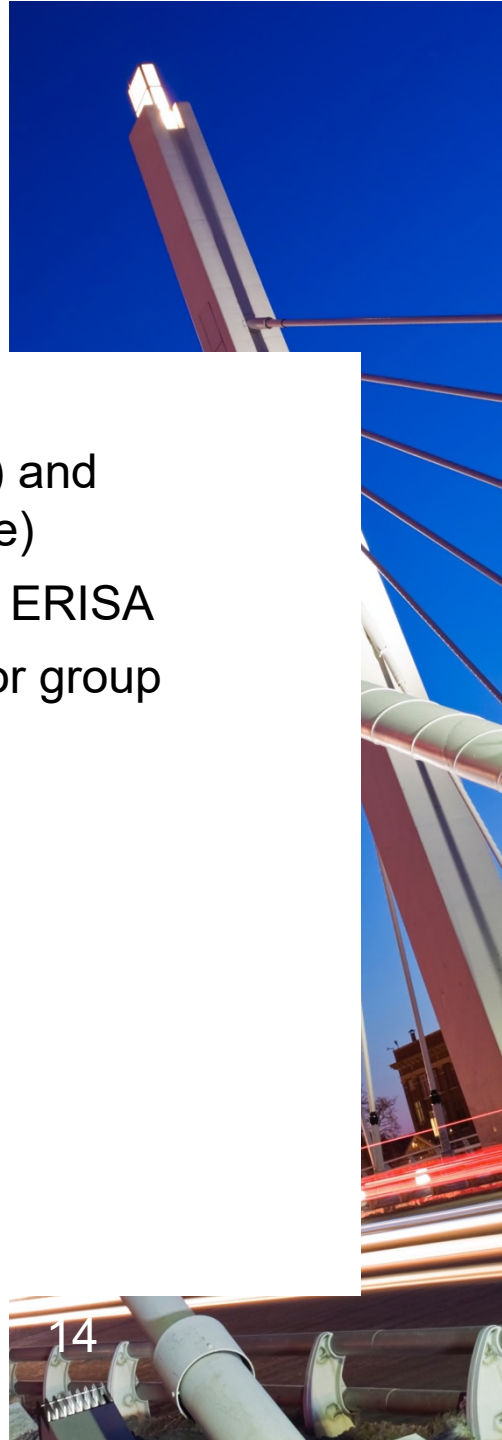
Transparency in Coverage Rule (TIC RULE)



- Effective January 1, 2022 for public disclosures (enforcement delayed until July 1, 2022) and January 1, 2023 and/or 2024 for individualized disclosures (depending on item or service)
- Statutory authority is in the Affordable Care Act amending Public Health Service Act and ERISA
- Applies to non-grandfathered group health plans and health insurers offering individual or group coverage (collectively Plans)

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Transparency in Coverage Rule (TIC Rule) (cont'd)

Purposes and Goals

- Help ensure competitive market by making information available
- Provide necessary information to patients so they can make informed choices
- Reduce surprises
- Downward pressure on prices and narrow price dispersion for some items and services

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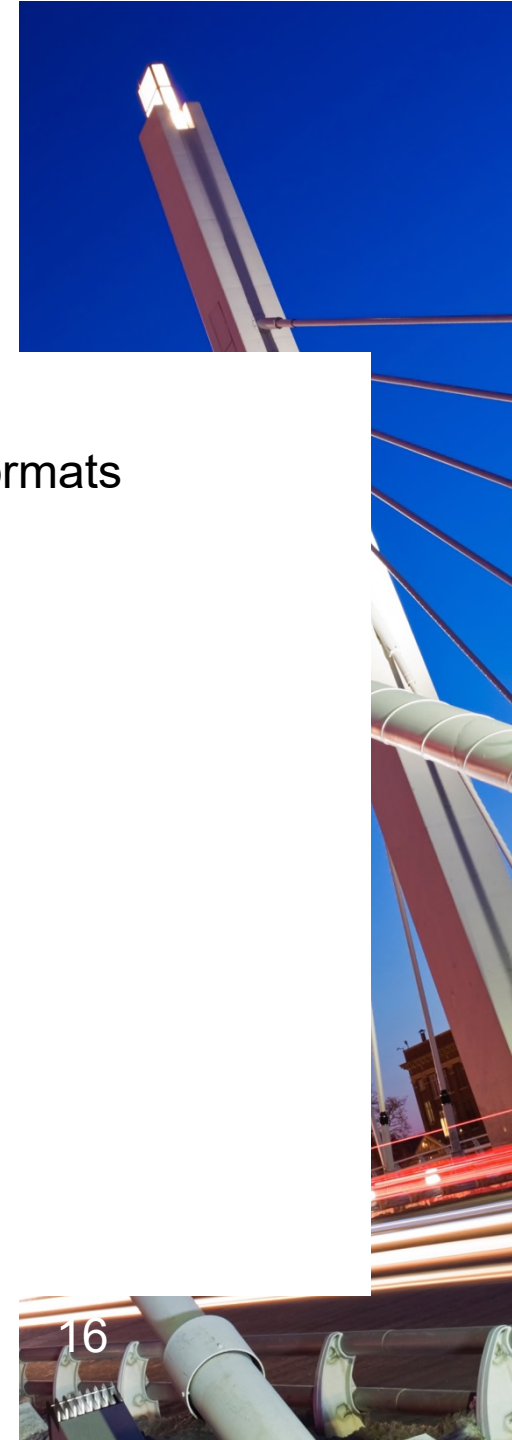
What Does TIC Rule Require?

- Individualized disclosures upon request of a participant through defined methods and formats
- Public disclosure of certain information in machine-readable files on a public website



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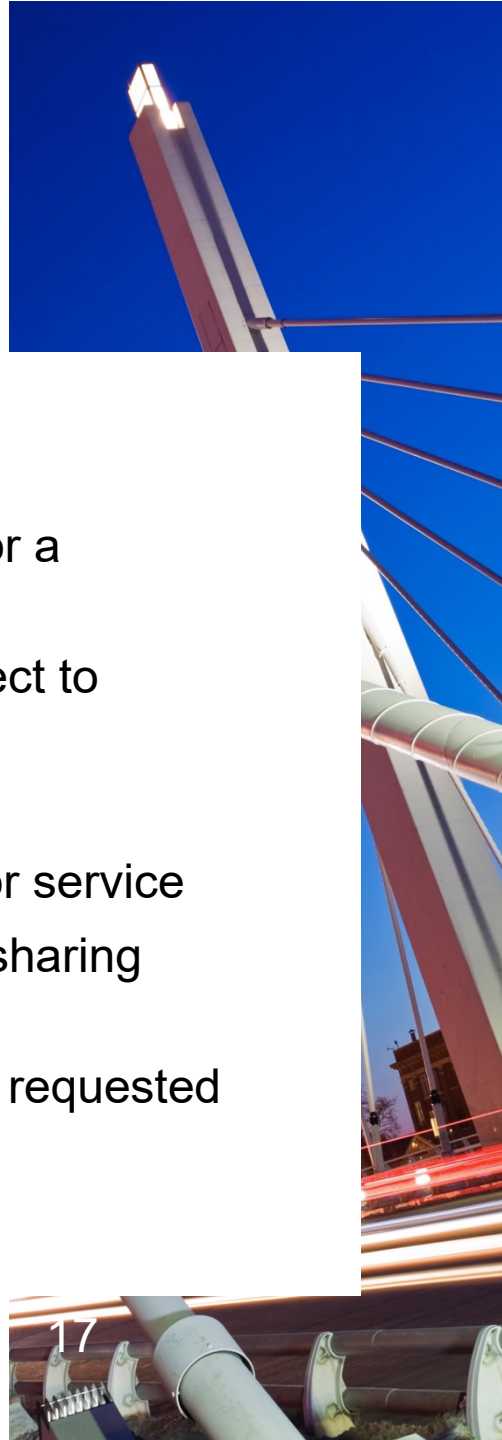
Requirement for Personalized Disclosure Upon Request



Requirement: At the request of an enrolled participant, a Plan must provide:

- An estimate of the participant's cost-sharing liability (amount to be paid by participant) for a requested item or service furnished by a provider
- Accumulated amounts (amount at time of request the participant has incurred with respect to deductible or out-of-pocket limits)
- The in-network rates, namely
  - The contractually negotiated rate with the in-network provider for the requested item or service
  - The underlying fee schedule rate for the item or service (rate used to determine cost-sharing liability for participant)
- The out-of-network allowed amount or other rate reflecting what the Plan will pay for the requested item or service if to be provided by an out-of-network provider

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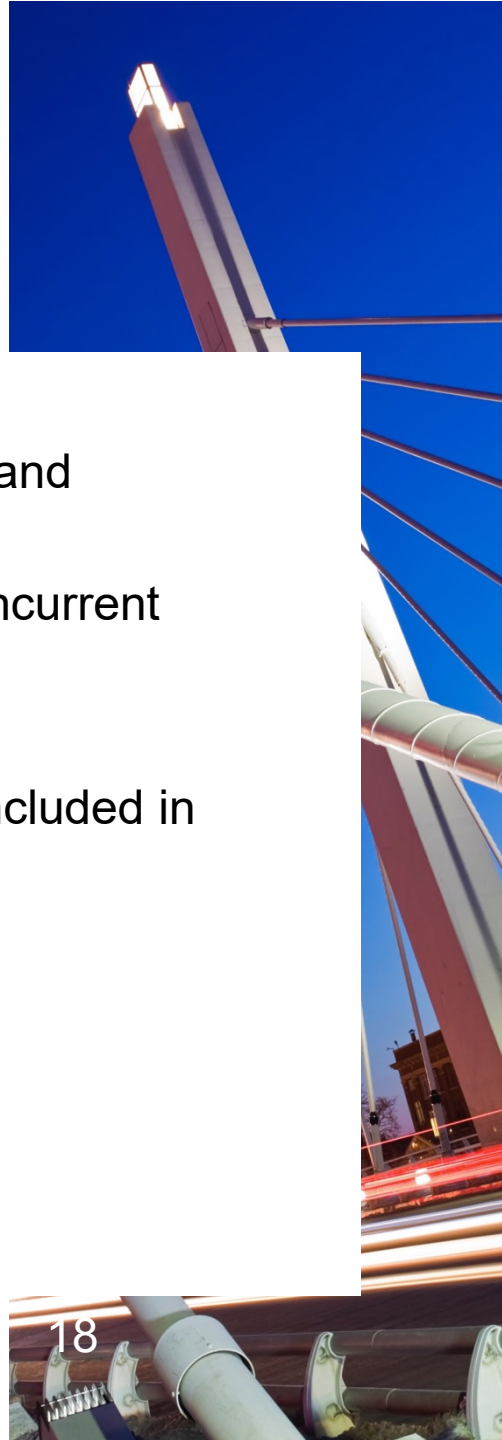
Requirement for Personalized Disclosure Upon Request (cont'd)



- If the request for an item or service is a bundled payment arrangement, the list of items and services included in the bundle
- Any pre-requisites for coverage of the item or service (examples, prior authorization, concurrent review, but not medical necessity determination)
- Statements that
  - Out-of-network provider may balance bill participants and that the balance bill is not included in the cost-sharing estimate
  - That it is an estimate based on the request and items and services may be different
  - That the estimate is not a guarantee that items or services will be provided

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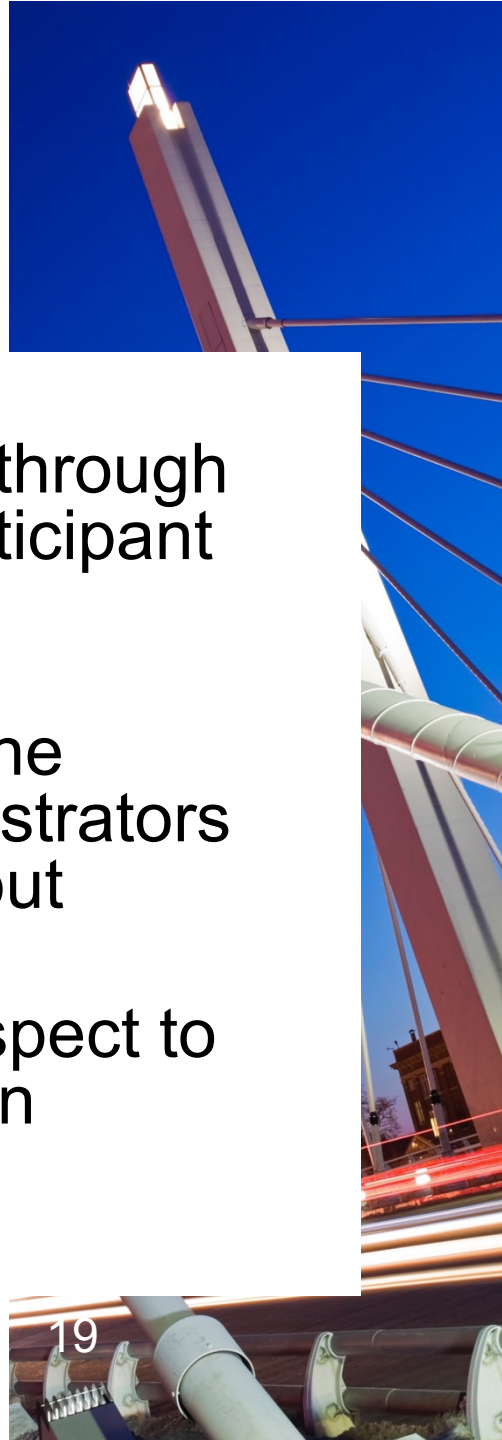
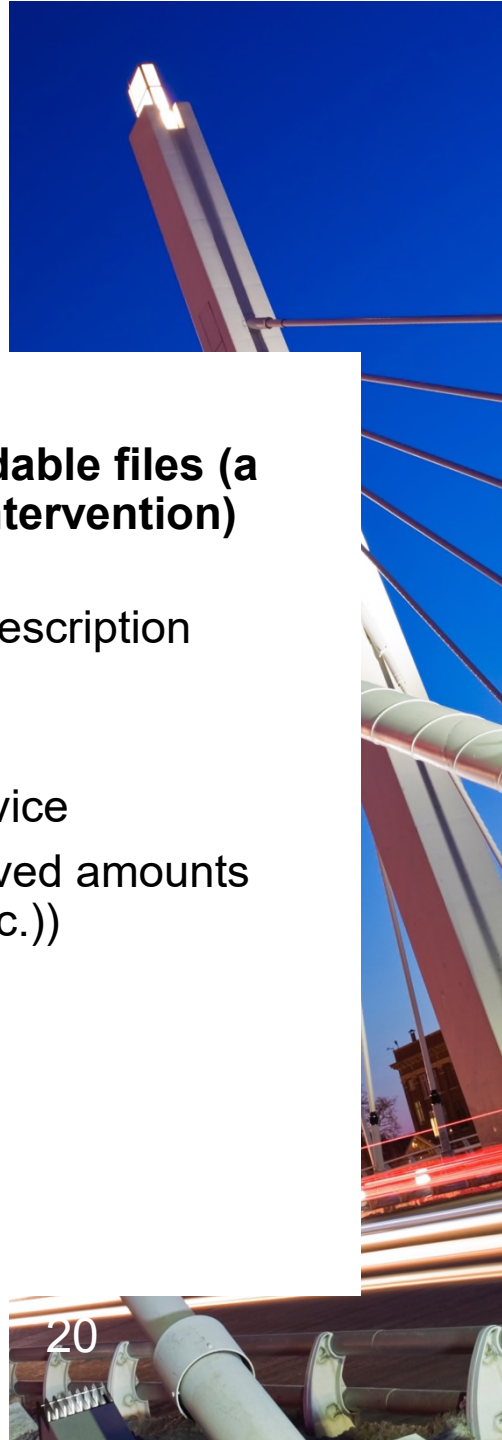
Requirement for Personalized Disclosure Upon Request (cont'd)



- Information must be provided in plain language, without fee, through a self-service tool on an internet website that permits the participant to search for information from the provider and all in-network providers or in paper form upon request
- Plans may comply with the TIC Rule through contracts with the insurer (for group health insurance) or with third-party administrators such as a PBM or TPA (for self-funded group health plans), but liability remains with the self-funded plan
- Applicable for plan years on or after January 1, 2023 with respect to 500 items or services to be posted on a public website and on January 1, 2024 for other items and services

Requirement for Public Disclosure



Requirement: Plans are required to make available on a public website in 3 machine-readable files (a digital file of data that can be imported and read by a computer system without human intervention) the following

(1) An in-network rate machine-readable file that includes for all items and services (except prescription drugs which are reportable in a separate file)

- For each coverage option offered, the plan identifier
- A billing code and a plain language description for each code for each covered item or service
- All applicable rates (which includes negotiated rates, underlying fee schedule rates or derived amounts (the rate assigned by the Plans for internal accounting, reconciliation with the providers, etc.))
- Dollar amounts for each covered item or service
- NPI, TIN and Place of Service Code for each in-network provider
- Last date of contract term
- Reimbursement arrangement if not fee-for-service

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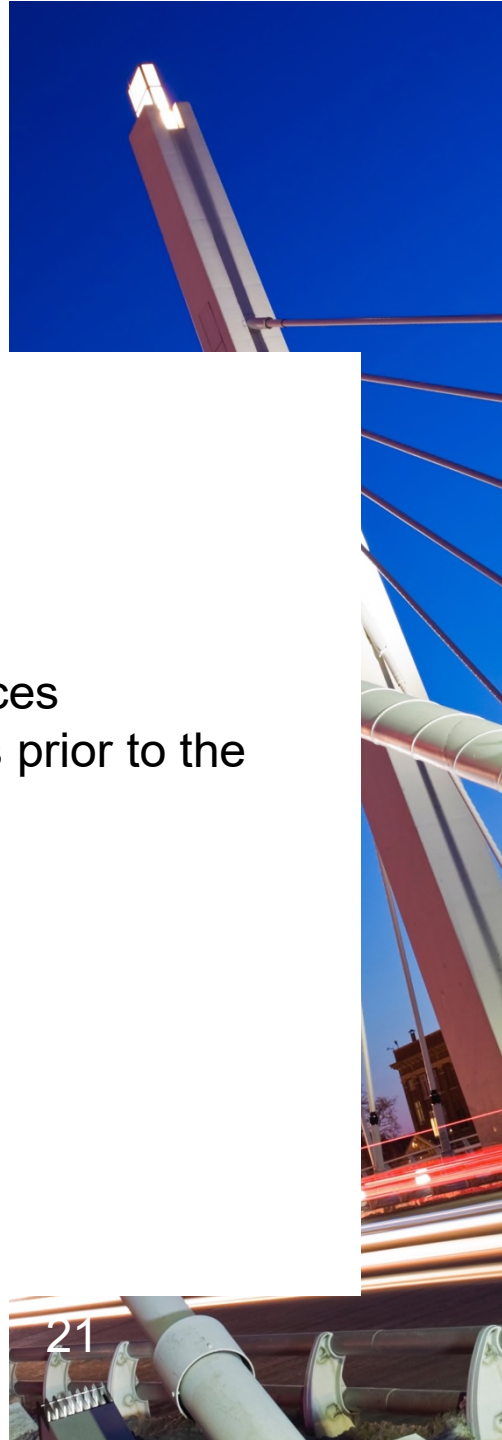
Requirement for Public Disclosure (cont'd)



(2) An out-of-network allowed amount machine-readable file that includes

- For each coverage option, the plan identifier
- A billing code and a plain language description of each covered item or service
- Unique out-of-network allowed amounts and billed charges for covered items or services furnished by out-of-network providers during a 90-day time period beginning 180 days prior to the publication date
- Each allowed amount must be
  - Reflected as a dollar amount
  - Associated with a NPI, TIN and Place of Service for the out-of-network provider

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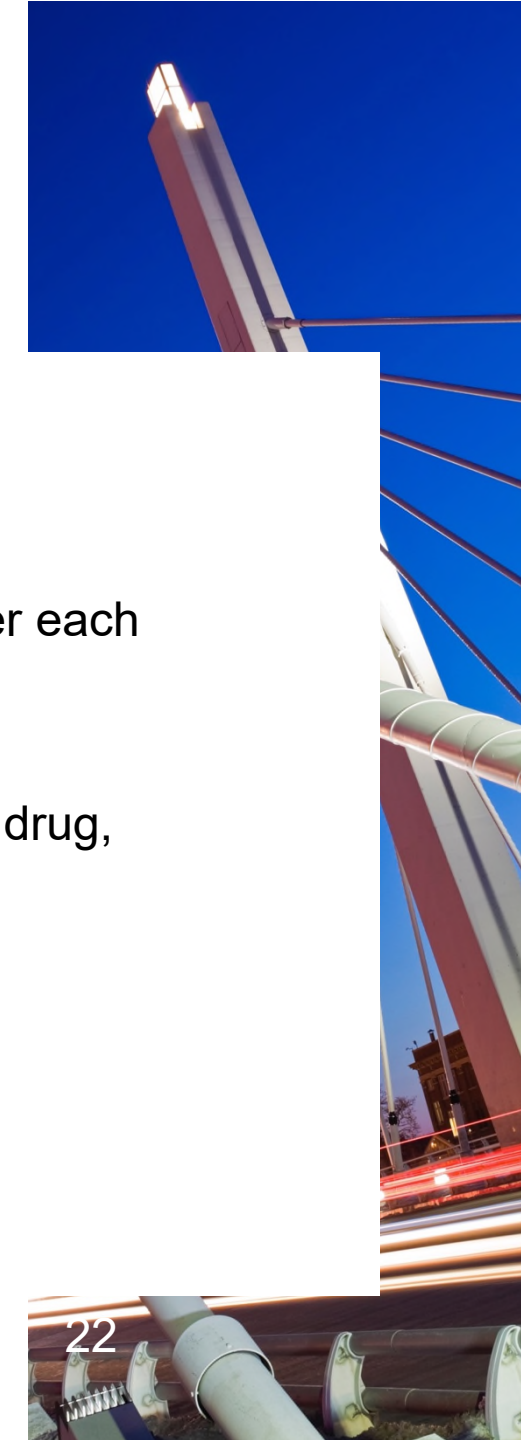
Requirement for Public Disclosure (cont'd)

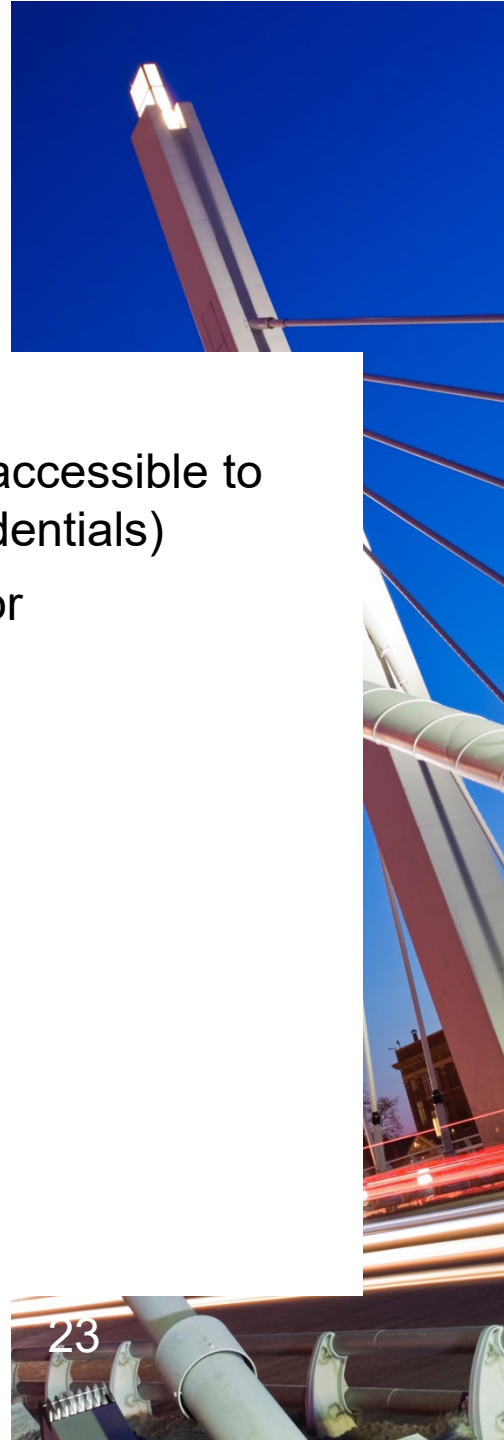


(3) A prescription drug machine-readable file that includes

- For each covered option, the plan identifier
- The NDC and proprietary name assigned to the NDC for each prescription drug under each coverage option
- The negotiated rate
- Historical net prices (the retrospective average amount a Plan paid for a prescription drug, inclusive of discounts, rebate fees, etc.)

Enforcement is delayed indefinitely, pending further rulemaking.

Requirement for Public Disclosure (cont'd)



- The 3 machine-readable files must be updated monthly, must be publicly available and accessible to anyone free of charge and without conditions (such as a user account, password or credentials)
- The requirements may be satisfied by certain contracts with insurers/TPA as specified for personalized disclosures

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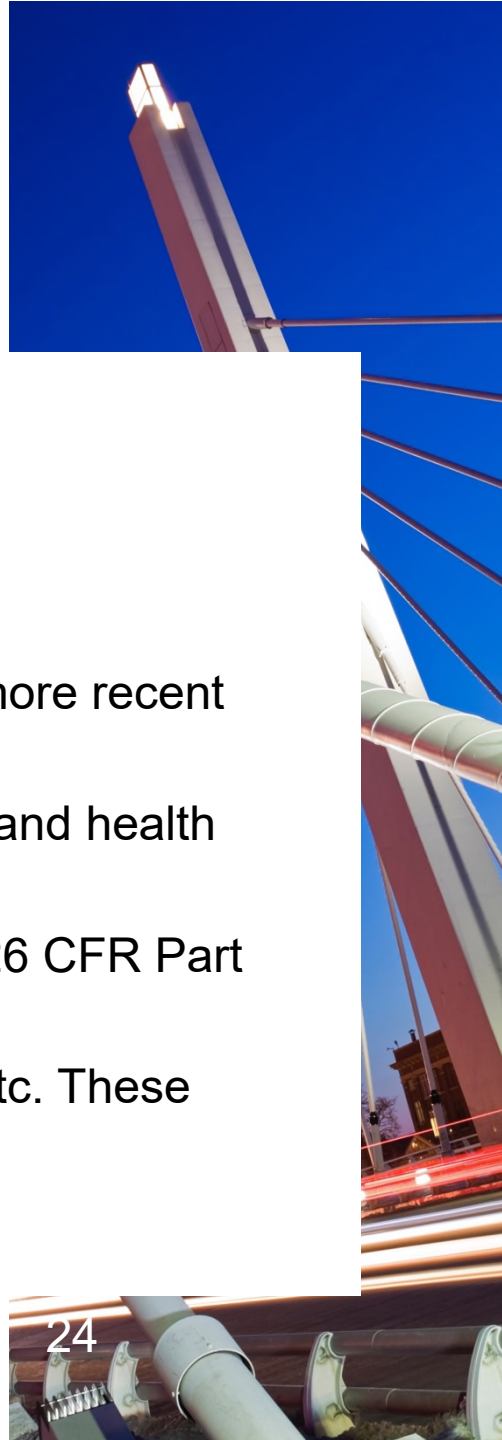
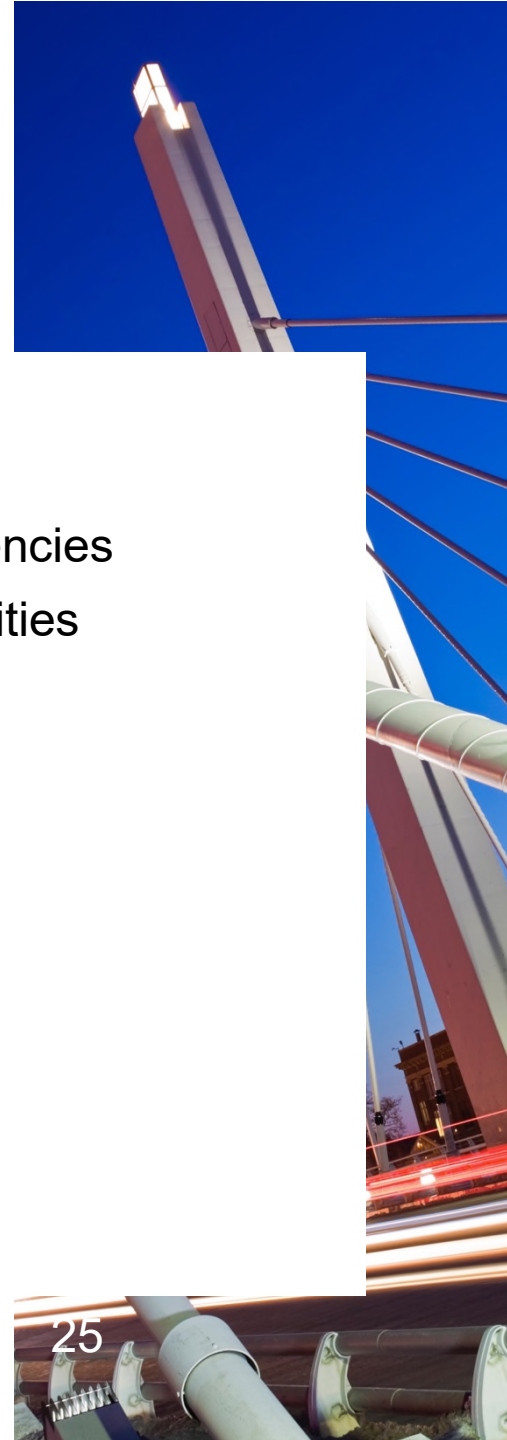
NO SURPRISES ACT (NSA): BACKGROUND



- Enacted as part of Consolidated Appropriations Act, 2021
- Regulations issued in two parts
  - First, related to Surprise Billing
  - Second, Independent Dispute Resolution and requirement for Good Faith Estimate (more recent update)
- Provisions apply to health care providers, facilities, providers of air ambulance services and health benefit plans
- Regulations codified at 45 CFR Part 144, 147 and 149 (HHS); 5 CFR Part 890 (OPM), 26 CFR Part 54 (IRS), 29 CFR Part 2590 (DOL)
- NSA does not apply to federal program beneficiaries such as Medicare, Medicaid, VA, etc. These have separate protection

NO SURPRISES ACT (NSA): PROBLEMS ADDRESSED



Problems addressed by NSA

- Unexpected bills when patient cannot select an in-network provider, including in emergencies
- Protect against bills from out-of-network providers furnishing services at in-network facilities
- Limit treatment and amount of out-of-network cost-sharing charges to a patient
- Eliminate balance billing in certain situations
- Establish independent dispute process for OON payer/provider payment dispute
- Require provision of Good Faith Estimate for uninsured/self-insured

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NO SURPRISES ACT (NSA): PROBLEMS ADDRESSED (cont'd)

- OON cost sharing and surprise bills do not count toward the deductible or maximum out-of-pocket limit
- 39% of ED visits to in-network facilities resulted in OON bills
- 37% of inpatient admissions to an in-network hospital had OON bills
- Incidence and amount of OON bills increasing
- Limit balance bills and OON cost-sharing amounts

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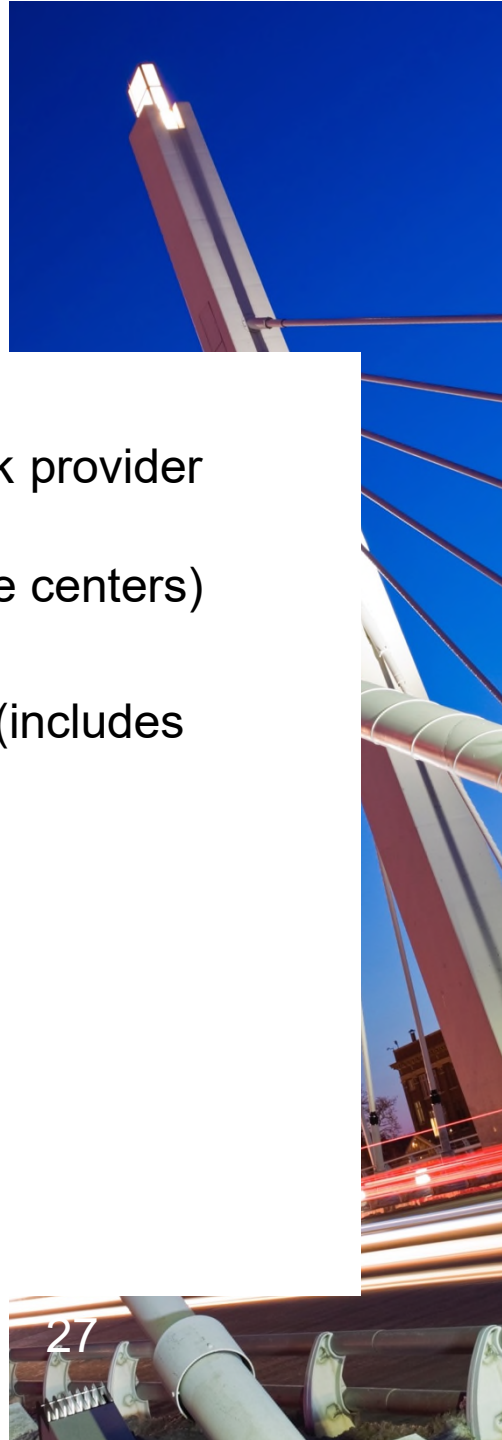
Surprise Billing



- Generally applicable in situations where patient may not or does not select an in-network provider and where provider may **balance bill**
  - Emergency services (whether or not facility is in-network) (includes certain urgent care centers)
  - Air ambulance services
  - Non-emergency services provided by out-of-network providers at in-network facilities (includes hospital outpatient departments, CAH, ASC's, but not urgent care centers)
- NSA (including regulations) with respect to Emergency Services requires –
  - If a Plan covers any benefits for Emergency Services they must be covered
    - Without any prior authorization
    - Regardless if provider is in-network
    - Regardless of any other term or condition

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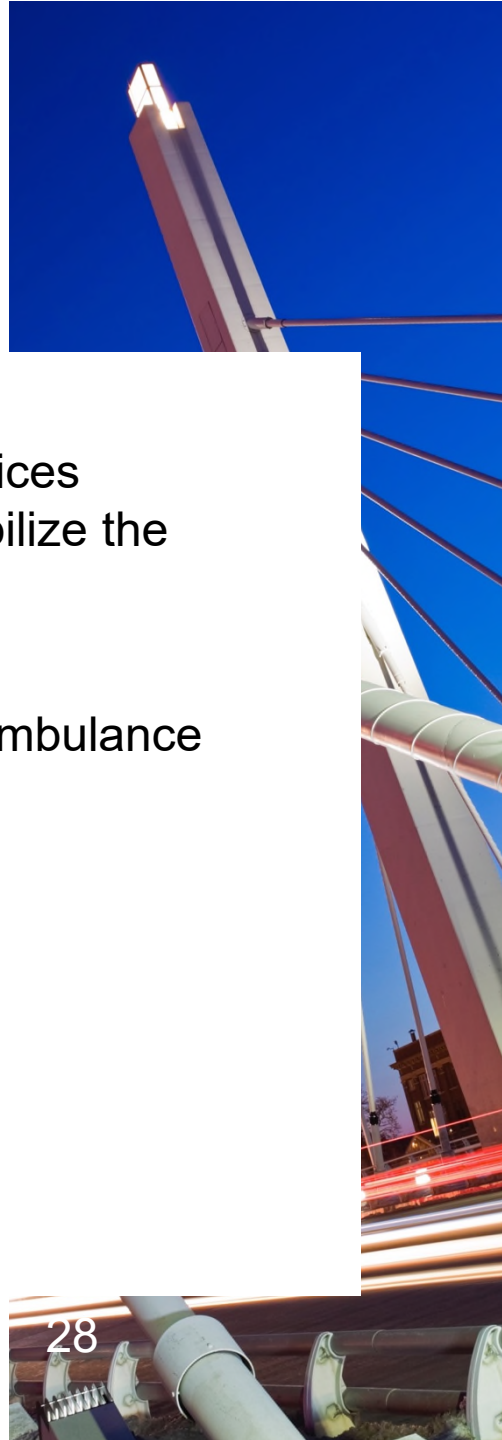
Surprise Billing (cont'd)



- "Emergency Services" include – medical screening examination, including ancillary services routinely available to the ED; further medical examination and treatment required to stabilize the patient; certain post-stabilization items and services
- Limits on cost-sharing amounts
- Cost-sharing amounts charged to patients for out-of-network Emergency Services, Air Ambulance Services of OON providers and OON providers at in-network facilities
  - May be no higher than "in-network levels"
  - Count toward any in-network deductibles and out-of-pocket maximums
- Balance billing is generally not allowed in such situations
  - Certain providers may seek patient waivers of prohibition

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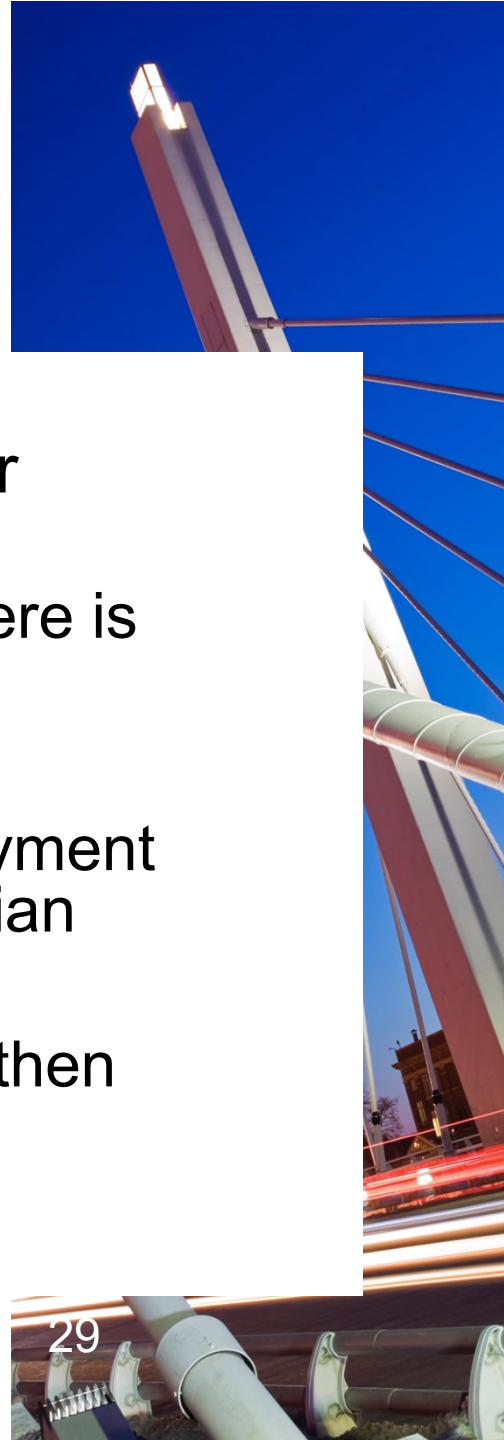
Surprise Billing (cont'd)



- How to determine the rate for cost-sharing and OON provider reimbursements in these applicable situations?
  - (1) Amount determined by the All-Payer Model Agreement (if there is one)
  - (2) Then state law, if state law specifies a rule
  - (3) For cost-sharing payable by patient, then the "Qualifying Payment Amount" ("QPA") – generally lesser of billed charges or median contracted rate of the Plan
  - (4) For the total amount payable to the provider, if not (1) or (2) then

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Surprise Billing (cont'd)

  - Amount as agreed between Plan and provider or facility
  - If no agreement, amount determined by independent dispute resolution (IDR)
- Notices required of certain providers and facilities on website and to individuals
  - Notice of the applicable requirements and prohibitions
  - Any applicable state balance billing limits
  - How to contact state or federal agencies if believe there is a violation

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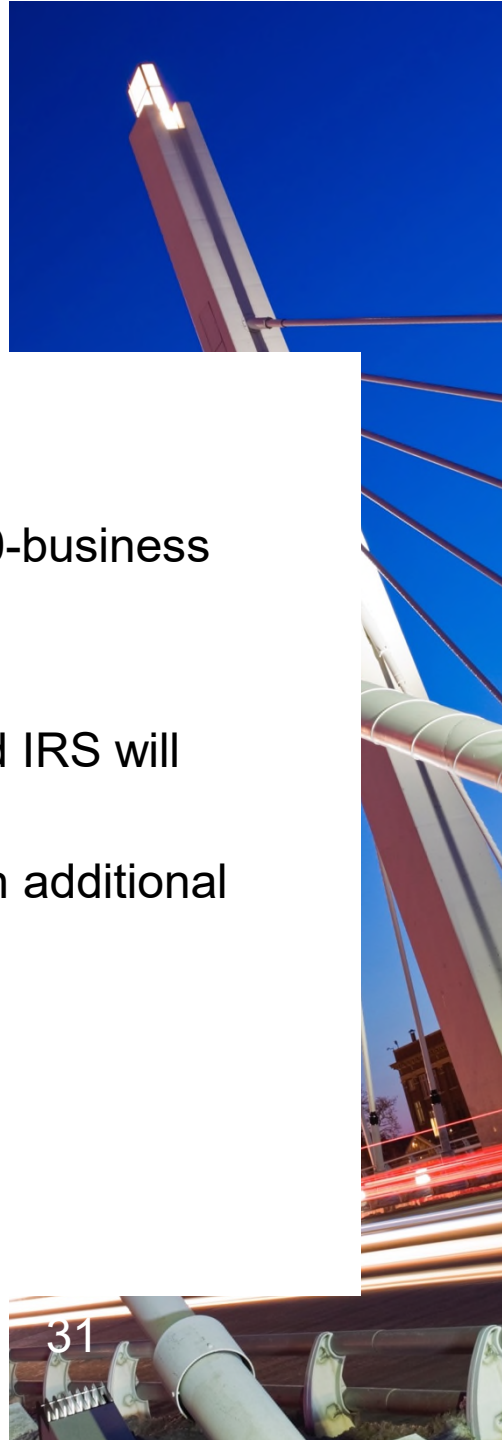
NSA: How Does Independent Dispute Resolution Work?



- If balance billing prohibited by NSA, IDR available to determine out-of-network rate
- If rate needs to be determined (no specified state law on All-Payer Model Rule) first – 30-business day negotiation period
- If that fails, either party may start IDR process within 4 business days
- Joint selection of certified IDR entity (if can't agree in 3 business days – HHS, Labor and IRS will select one)
- Both parties must submit their offers within 10 business days to the IDR entity along with additional information
- Offers must be stated as a dollar amount and as a percentage of the QPA

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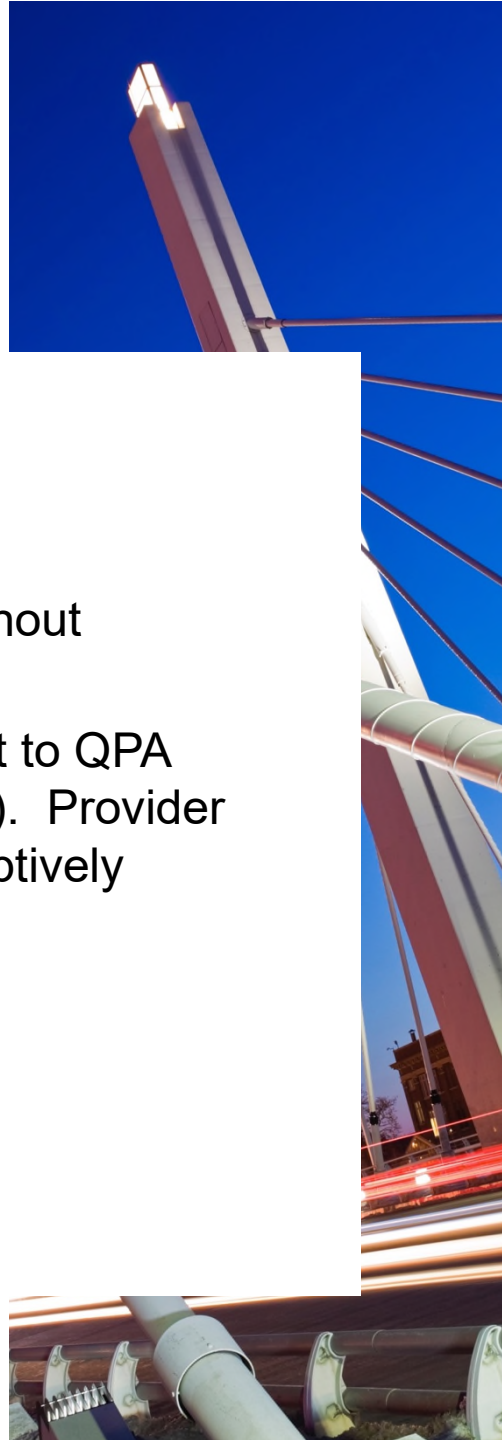
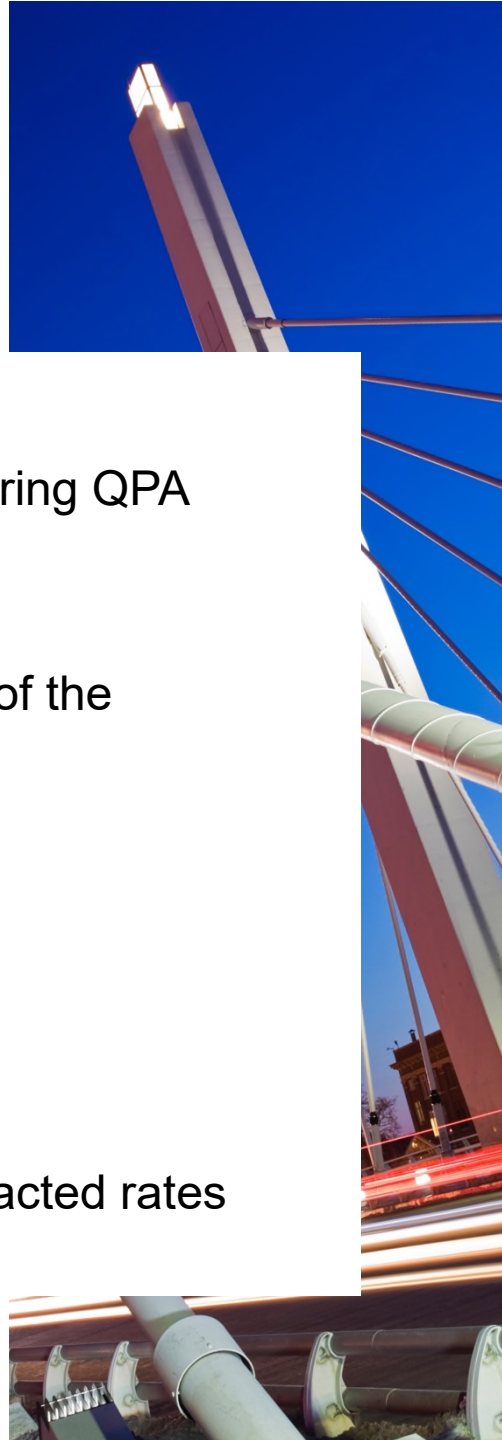
IDR Process (cont'd)



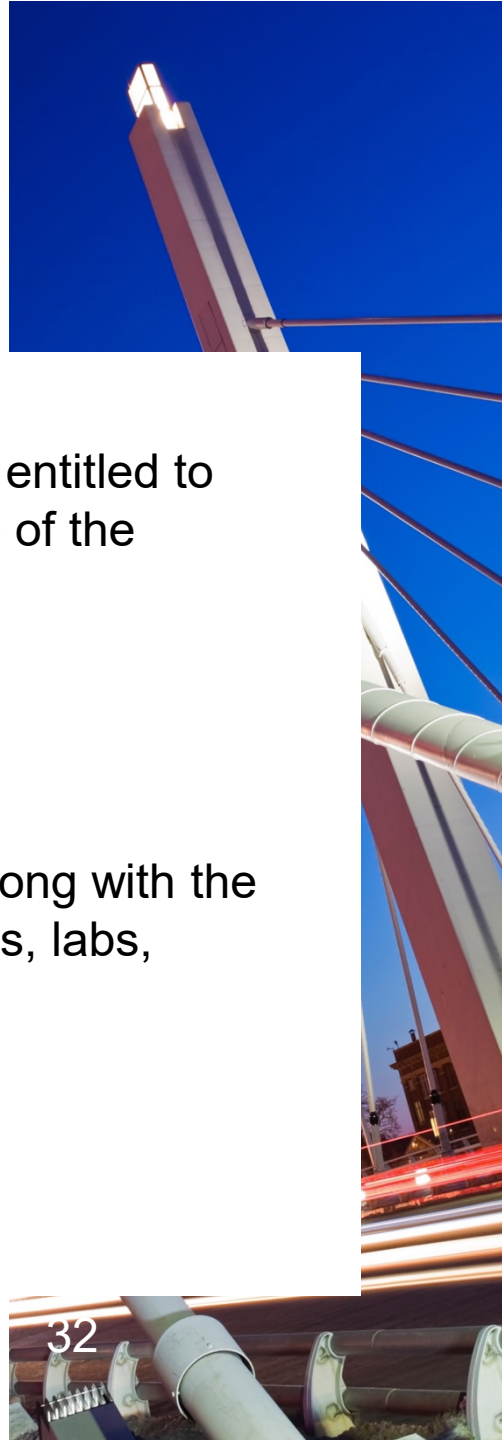
- IDR entity must select one of the offers as binding (baseball arbitration)
- IDR entity must provide a written explanation of its choice
- Under NSA, IDR entity cannot consider what public payers pay; the amount payable without balance bill prohibitions; usual and customary charges
- Initially QPA was presumptively favored as the rate (IDR Entity was to select rate closest to QPA unless credible information shows QPA materially difference from appropriate OON rate). Provider associations brought litigation and a Texas District Court vacated portion of rule presumptively favoring QPA

IDR Process (cont'd)



- Departments issued revised regulations in August of 2022, eliminating presumption favoring QPA and addressing downcoding
- New regulation requires Plan to disclose whether code was downcoded and why
- New regulation requires IDR entity to determine the offer that best represents the value of the service (no presumption favoring QPA)
- IDR must consider
  - Training and experience of provider
  - Market share held by provider and Plan
  - Patient's acuity and complexity of treatment
  - Pending status, case mix and scope of services of facility
  - Good faith efforts of Plan and efforts to enter into network agreements and prior contracted rates

NSA: Good Faith Estimate

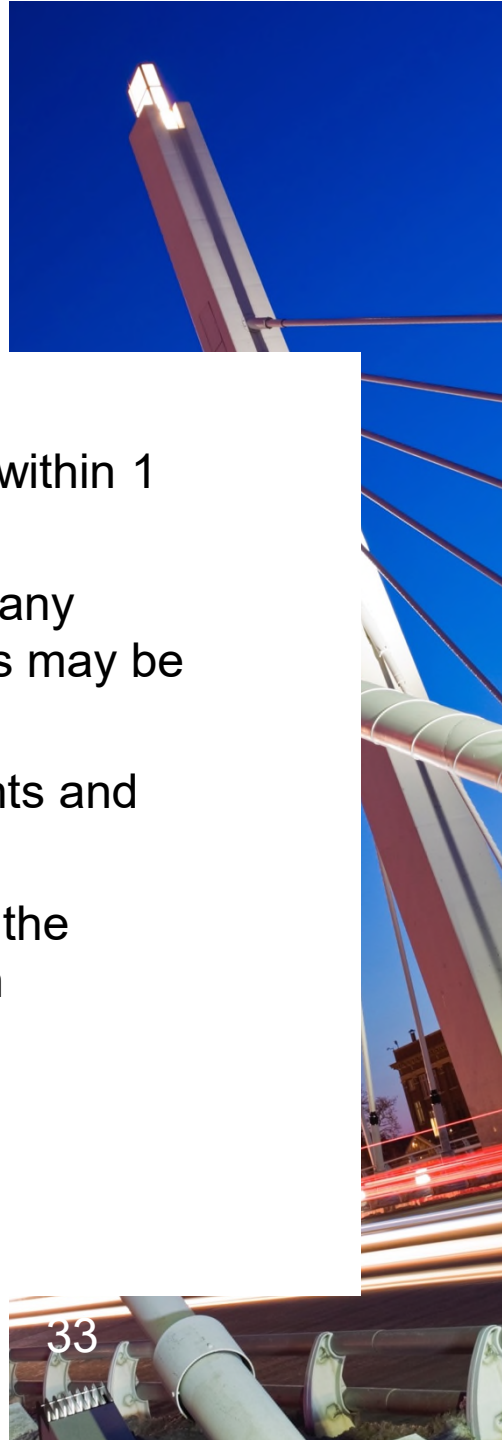


- Uninsured or self-pay (those who elect not to submit the claim for insurance) individuals entitled to receive a Good Faith Estimate. The provider/facility must provide a Good Faith Estimate of the expected charges for the items or services upon request
- Any discussion or inquiry of costs is considered a request
- Not required if services not typically scheduled in advance
- The Good Faith Estimate must include
  - Expected charges or items or services that are reasonably expected to be provided along with the primary item or service (including items or services to be provided by others (examples, labs, anesthesia) subsequent PT for a surgery not included)
  - Name of each expected provider including NPI and TIN
  - List of items or services that will require separate scheduling

Good Faith Estimates

- Convening Provider (often facility providing the primary service) must seek price confirmations from other providers
- Time periods to provide GFA by Convening Provider
  - If scheduled at least 3 business days in the future, 1 business day after scheduling
  - If scheduled at least 10 business days in the future, 3 business days after scheduling
  - If GFA requested but no scheduled date, then within 3 business days

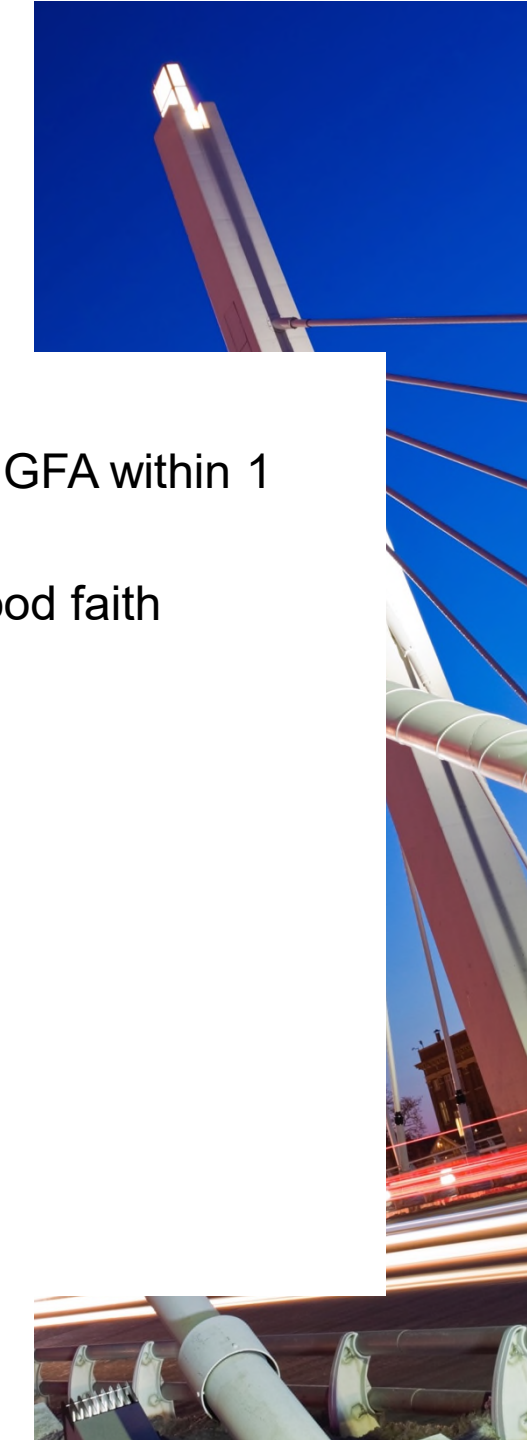
NSA: Good Faith Estimate (cont'd)



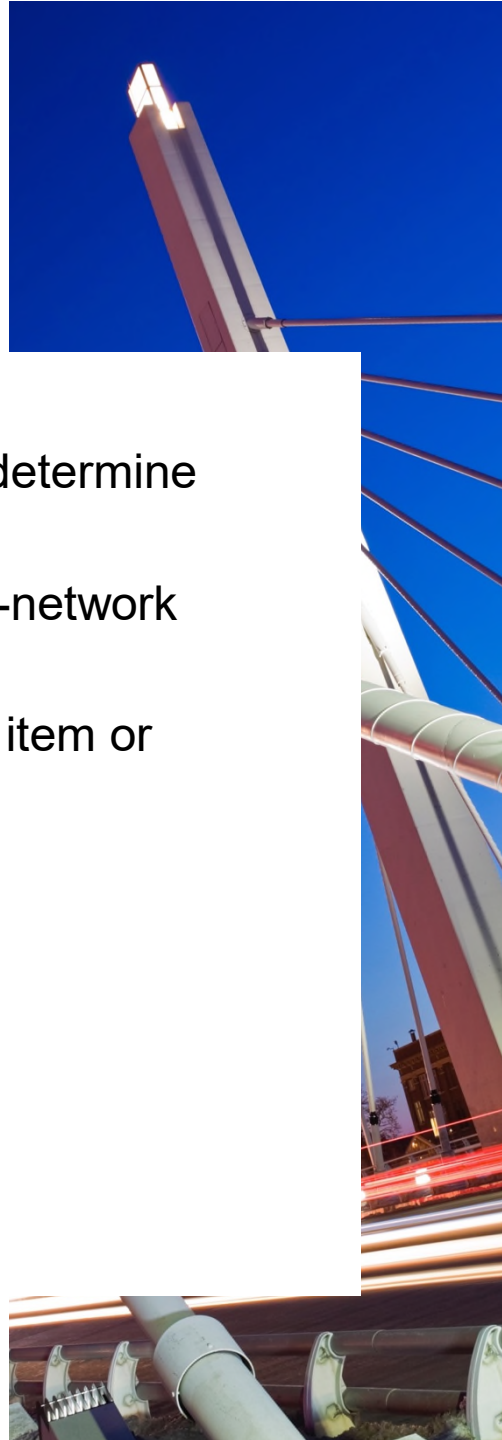
- Convening Provider must contact other providers expected to provide items or services within 1 business day; other co-providers must respond within 1 business day
- If Good Faith Estimate received and bill is "substantially in excess" (defined as $400 for any provider or facility charges) of the Good Faith Estimate then a dispute resolution process may be pursued by patient
- Patient has 120 days to initiate dispute resolution. Timelines for submission of documents and determination. Dispute resolution entity will make payment determinations
- Provider must submit a copy of the GFA, a copy of billed charges and documentation of the difference and why a medically necessary item or service that was based on unforeseen circumstances that could not have been reasonably anticipated when estimate provided

Good Faith Offer (cont'd)

- After Good Faith Offer, if circumstances change Convening Provider must issue a new GFA within 1 business day before tem or service is scheduled to be furnished
- Convening Provider may correct an error or omission before treatment provided if in good faith



NSA: Good Faith Estimate (cont'd)



- Selected Dispute Resolution Entity has 30 business days from receipt of information to determine amount to be paid
- If SDR entity agrees with provider, then payment is lesser of billed charges or median in-network amount from a database
- If SDR entity does not agree with provider, then payment amount is the GFA or, if a new item or service, is included - $0
- No bills can be sent or collection pursued during resolution process

QUESTIONS?