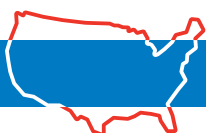
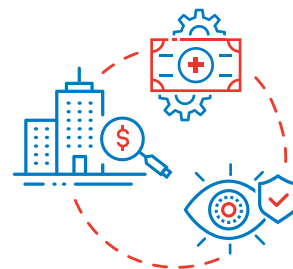


Price Transparency: A Primer On State, Federal Requirements

Texas hospitals believe consumers should be engaged in their own health care decisions, with easily accessible information necessary to make prudent choices about their health care. **As consumers are asked to bear a larger share of health costs**, whether through high-deductible health plans or alternatives to health insurance with limited reimbursement, **interest in price transparency has grown**. A variety of health care cost transparency initiatives at the state and federal levels aim to make fee/price information more readily available to consumers, and Texas hospitals continue to work to ensure they are engaged in this work and meeting the needs of patients and other consumers. To date, regulation has focused largely on disclosure of hospital pricing information. **However, deductibles and insurance premiums are the payments that ultimately impact a consumer's out-of-pocket costs.**



FEDERAL LAWS



CMS Requires Hospitals to Post Charges and Negotiated Rates with Health Insurers

Effective Jan. 2, 2021, federal rule CMS-1717-F2 requires hospitals to post, in machine-readable format online, a list of five types of standard charges for all items and services:

- Gross charges;
- payor-specific negotiated rates;
- de-identified minimum negotiated rates;
- de-identified maximum negotiated rates; and
- discounted cash prices.



In addition, CMS requires hospitals to display, in an easy-to-understand format, negotiated charges and other relevant information for 300 “shoppable” items and services. This information must display a patient's expected out-of-pocket costs for non-urgent health care services that can be scheduled in advance. The maximum annual penalty for violating the rule is \$2,007,500 per hospital and the minimum annual penalty is \$109,500 per hospital. CMS set the minimum civil monetary penalty at \$300 per day for smaller hospitals with a bed count of 30 or fewer, and a penalty of \$10 per bed per day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of \$5,500.

CMS Requires Payors to Post Pricing Information

Under the Transparency in Coverage Final Rule (CMS-9915-F), beginning July 1, 2022, most group health plans and issuers of group or individual health insurance will begin posting pricing information for covered items and services. Payors will be required to post machine-readable files with in-network rates for plan issuers and providers, as well as allowed amounts for, and billed charges from, out-of-network providers. More requirements will go into effect starting Jan. 1, 2023, and Jan. 1, 2024, that will provide additional access to pricing information and enhance consumers' ability to shop for the

health care that best meets their needs. Payors will be required by 2023 to have an internet-based price comparison tool (or a paper disclosure, if requested), allowing an individual to receive an estimate of their cost-sharing responsibility from a specific provider for 500 items and services. By 2024, the internet-based price comparison tool must include all items and services. Payors are subject to a civil monetary penalty of up to \$100 per violation per day.

The No Surprises Act Prohibits Balance Billing and Creates Increased Predictability for the Cost of Care

On Dec. 27, 2020, the No Surprises Act was signed into law as part of the Consolidated Appropriations Act of 2021. Beginning Jan. 1, 2022, out-of-network hospitals may not balance bill patients for covered emergency services. In addition, non-facility providers may not balance bill patients for certain covered non-emergency services provided at in-network facilities (unless the patient consents in advance). Patient cost sharing is based on a defined amount and is limited to the patient's in-network deductible. The bill sets up an independent dispute resolution process for providers and payors. The bill also requires, effective Jan. 1, 2023, providers to furnish good faith estimates for all uninsured/self-pay scheduled services scheduled three or more days out and when requested by an uninsured/self-pay patient. One provider ("the convening provider") is required to coordinate estimates across all providers and deliver one good faith estimate to the patient.

The ACA Requires Hospitals to Publish Charges

The Affordable Care Act requires every hospital to annually establish and make public a list of its standard charges for items and services provided. Beginning Jan. 1, 2019, hospitals were required to publish standard charges for all items and services on a public-facing website in a machine-readable format and update this information at least annually, or more frequently, as appropriate, according to an August 2018 rule from the Centers for Medicare & Medicaid Services. CMS interprets the rule to require hospitals to post information representing "the hospital's current standard charges as reflected in its chargemaster." CMS interprets "machine-readable format" as a digitally accessible document easily imported/read into a computer system (e.g., XML, CSV), rather than a PDF. CMS later expanded this rule to include in-network rates with payors.

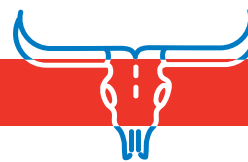
- In addition, non-profit hospitals must have publicly available written financial assistance policies for uninsured patients and those unable to pay for health care, which include eligibility criteria, the basis for calculating charges and the method for applying for financial assistance.

FAIR Health: Independent Repository of Claims Data

- FAIR Health, the result of a 2009 settlement with 12 health insurers in New York, is an independent repository of claims data provided by procedure code or by episode of care that also provides cost estimates. Charges and reimbursement rates are provided on both an in-network and out-of-network basis. Claims are organized by a geographic area ("geozip"), usually based on the first three numbers of a zip code. FAIR Health groups charges into percentiles, from lowest to highest. For example, if a provider's price is in the 80th percentile for a certain service, 80% of the fees billed by other providers for the same service were that amount or lower.



TEXAS LAW



SB 1137: Texas Law Codifies and Expands Federal Rules on Posting Prices and Imposes New Penalties

SB 1137, 87th R.S., with a few exceptions, codifies into state law federal rule CMS-1717-F2 (effective since Jan. 2, 2021), which requires hospitals to post on the internet, in machine-readable format, a list of standard charges for all payors comprised of:

- Gross charges;
- payor-specific negotiated charges (negotiated rates);
- de-identified minimum and maximum negotiated charges (the highest and lowest rates a hospital has negotiated with all third-party payers for an item or service); and
- discounted cash prices.

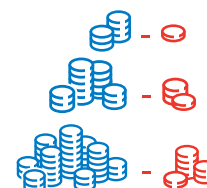


Shoppable Services. In addition to a machine-readable file of all standard charges, hospitals must post standard charge information for 300 shoppable services, which can be scheduled in advance, in a consumer-friendly way that is both easily understood and searchable. CMS has defined 70 shoppable services that hospitals must post. Hospitals must identify the remaining 230 shoppable services based on common services for the populations they serve. Hospitals can meet the shoppable services requirement by voluntarily offering an internet-based tool that provides a price estimate for at least 300 such services, including for as many as the 70 CMS-specified services as offered at the hospital if it allows consumers to obtain an estimate of their expected out-of-pocket costs while using it. The price estimator tool must be displayed prominently on the hospital's website and be readily accessible to the public without charge or having to register or establish a user account or password.

Easy Online Access and Ongoing Reporting Obligation to the State. Standard charges and information for the 300 shoppable services must be posted in a prominent place on a hospital's websites, without requiring any form of patient registration or other "barrier" to access, and in a template developed by the Texas Health and Human Services Commission. SB 1137 requires hospitals to submit an updated list of the 300 shoppable services to HHSC annually. The list must also be available on an internet search engine, free of charge, without having to establish a user account or password, without having to submit personal identifying information and without having to overcome any other impediment, such as entering a code to access the list.

Penalties for Noncompliance. Under SB 1137, HHSC may impose penalties for noncompliance (in addition to any penalties imposed by CMS) as follows:

- \$10 for each day the facility violated, if the facility's total gross revenue is less than \$10 million;
- \$100 for each day, if the facility's total gross revenue is \$10 million or more and less than \$100 million; and
- \$1,000 for each day if the facility's total gross revenue is \$100 million or more.



HB 2090: Texas Law Mandates Health Plan Disclosures

HB 2090, 87th R.S., sets out new detailed cost disclosure requirements for all commercial health benefit plans regulated by the state. However, the bill does not apply to health reimbursement arrangements, other account-based health benefit plans or workers' compensation insurance policies. HB 2090 mandates new public disclosures for health benefit plan issuers and administrators currently not subject to reporting requirements under federal rule (CMS-9915-F). For plans renewed or effective after Jan. 1, 2022, a health benefit plan issuer or administrator must publish on a website machine-readable files that include a comprehensive breakdown of in-network rates and out-of-network rates. A requirement to provide detailed, individualized cost sharing information does not go into effect until 2024.

SB 1731: Texas Law Requires Reimbursement Data, Cost Estimates

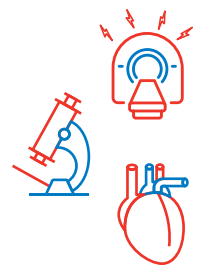
The Health Insurance Reimbursement Rates Consumer Information Guide, the result of Senate Bill 1731, 80th Legislature, requires the Texas Department of Insurance to collect data from health plans to determine their reimbursement rates for physicians and hospitals for specific medical services. It also requires TDI to combine all responses and present summary information based on the 11 Health and Human Services regions in Texas. Through its website, TDI reports the average billed, paid and contracted or allowed amounts for certain services, based on data provided by health insurers and HMOs in Texas.

SB 1731 also requires health plans, providers and hospitals to provide cost estimates to individuals who are uninsured or who are seeking out-of-network care. Patients choosing elective, inpatient services or nonemergency outpatient surgery may request an estimate of charges and payments, due within 10 days. Extending the charge estimate to emergency care would violate EMTALA, state and federal law that requires hospitals to provide emergency treatment and stabilization to anyone who needs it, regardless of their ability to pay.

SB 1264: Texas Law Addresses Balance Bills, Dispute Resolution

Effective Jan. 1, 2020, SB 1264, 86th R.S., prohibited out-of-network balance bills and created a dispute resolution process for:

- Out-of-Network Emergency Care (facility's bill or provider's bill);
- health care, medical service or supply provided at an in-network facility by an out-of-network physician, health care practitioner, or other health care provider (the provider's bill); and
- services provided by diagnostic imaging providers and laboratory service providers provided in connection with a health care service performed by a network physician or provider.



Texas hospitals supported the **prohibition on out-of-network surprise billing**. Under SB 1264, patients are held harmless for out-of-network surprise medical bills based on the care described above, as long as the health plan is regulated by the Texas Department of Insurance.



Texas Laws 