

# Price Transparency and Surprise Billing

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# Topics

1. Summary of the Price Transparency Rule
2. Background
3. Deep Dive into the Price Transparency Rule
4. A Look at the New Federal Surprise billing Law
5. Texas Law



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1. **Summary of the Price Transparency Rule**
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# A. Hospitals must post 5 “standard charges” on the internet.

Effective January 1, 2021, the CMS [final rule](#) requires hospitals to post in machine-readable format on the internet, a list of 5 types of standard charges for all items and services:

1. Gross charges;
2. Payer-specific negotiated rates;
3. De-identified minimum negotiated rates;
4. De-identified maximum negotiated rates; and
5. Discounted cash prices.

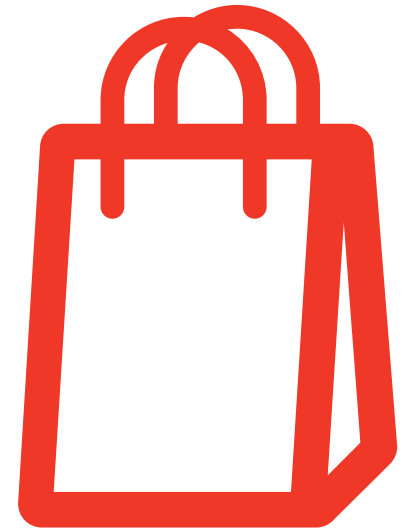


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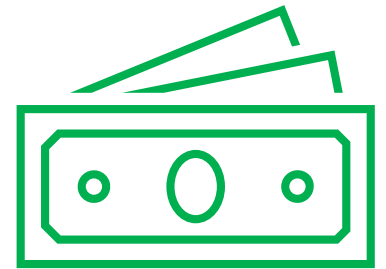
## B. Hospitals must also post 300 “shoppable” items and services.

- In addition, CMS required hospitals to display, in an easy-to-understand format, negotiated charges and certain other information for 300 “shoppable” items and services
  - information that displays a patient’s expected out-of-pocket costs for nonurgent health care services that can be scheduled in advance.



## C. CMS will Actively Enforce this Rule

- CMS will monitor and enforce compliance through review of [complaints](#) and audits of hospital websites.
- CMS [plans](#) to audit a sample of hospitals starting in January.
- CMS will first issue a warning, and if the violation continues, require the hospital to submit and follow a corrective action plan.
- If a hospital does not submit or adhere to a corrective action plan, CMS will impose a civil monetary penalty of up to \$300 a day.
- Hospitals will be required to pay the CMP in full within 60 days of receiving notice from CMS.



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# White House Policy

- **Executive Order: Improving Price and Quality Transparency in American Healthcare to Put Patients First (June 24, 2019)**

*“It is the policy of the Federal Government to ensure that patients are engaged with their healthcare decisions and have the information requisite for choosing the health care they want and need.”*

- Eliminate unnecessary barriers to price and quality transparency
- Increase availability of meaningful price and quality information for patients
- Enhance patients’ control over their own health care resources, including through tax-preferred medical accounts
- Protect patients from surprise medical bills



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# White House Policy (Continued)

- **Directs federal agencies to adopt proposed rules and reports**
  - **HHS** – Propose rules requiring hospitals to “publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format.”
  - **HHS, Treasury and Labor** – Issue advanced notice of proposed rulemaking soliciting comment on a proposal to require providers, health insurers and self-insured group health plans to “provide or facilitate access to information about expected out-of-pocket costs for items and services to patients before they receive care.”
  - **HHS, in consultation with the Attorney General and FTC** – Issue a report “describing the manners in which the Federal Government or the private sector are impeding healthcare price and quality transparency for patients” and provide recommendations for eliminating such impediments



# CMS' Response

- In 2019, CMS [posts](#) its CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1717-P)
  - Includes a requirement to post newly defined “payer-specific negotiated charges” and information that displays a patient’s expected out-of-pocket costs for 300 shoppable services.
  - The rule is finalized on Nov. 15, 2019
- On Nov. 12, 2019 CMS [proposes new requirements](#) on most health plans to make public their in-network negotiated rates and historic payments of allowed amounts to out-of-network providers.
  - That rule is [finalized](#) Oct. 29, 2020.



# Legal Challenge to the Rule



On Dec. 4, 2019, the AHA and three other national organizations representing hospitals and health systems [sued](#) the federal government, challenging CMS's final rule.

AHA [appealed](#) to the D.C. Circuit, *American Hospital Assn, et al. v. Azar*, No. 19-cv-3619 (D.D.C.. June 23, 2020).

The Texas Hospital Association joined 39 state hospital associations in an [amicus brief](#) filed on July 24.

On Jan. 7, AHA [urged](#) HHS to "exercise enforcement discretion" on the rule.

AHA was [not successful](#) at the trial court level.

On June 29, AHA [urged CMS](#) to delay the rule pending the outcome of the litigation.

That court again [upheld](#) the price transparency rule and declined to delay enforcement of the rule.

Fate of Litigation is unknown.



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# Recap of the CMS Price Transparency Rule

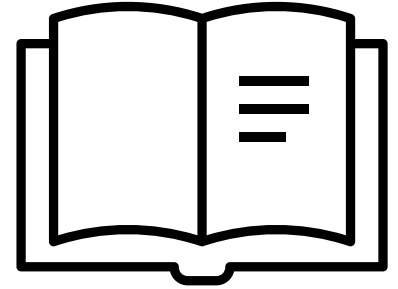
- Effective January 1, 2021, a CMS [final rule](#) required hospitals to post on the internet in, machine-readable format:
  - gross charges; payer-specific negotiated rates; de-identified minimum and maximum negotiated rates; and discounted cash prices.
- In addition, CMS required hospitals to display, in an easy-to-understand format, negotiated charges and certain other information for 300 “shoppable” items and services.



# Definitions

## Gross Charge

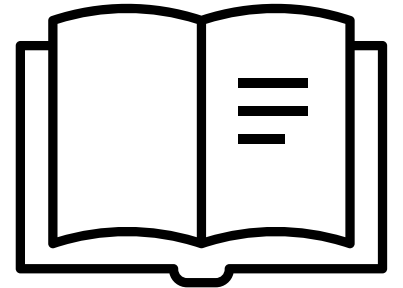
- The charge for an individual item or service that is reflected in the hospital's chargemaster, absent any discounts.
- Think of this as your chargemaster rate.
- Hospitals have been [required](#) to post these charges on the internet since 2019.



# Definitions (Continued)

## Payer-Specific Negotiated Charge

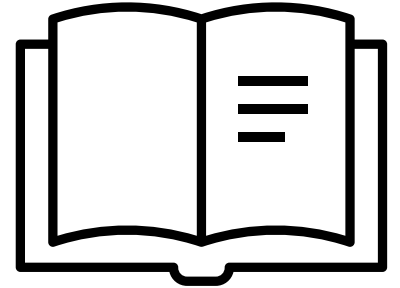
- The charge a hospital has negotiated with a third party payer for an item or service.
- A third party payer is defined as an entity legally responsible for payment of a claim for a health care item or service, including third party payer managed care plans, such as Medicare Advantage plans and Medicaid managed care plans.
- Fee-For-Service Medicare and Medicaid rates are not included in this definition.



# Definitions (Continued)

## Discounted Cash Price

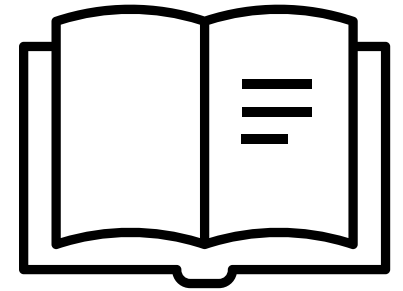
- The charge that applies to an individual who pays cash (or cash equivalent) for a hospital item or service, often referred to as the “walk-in” rate.
- This price is not charity care or bill forgiveness that a hospital may choose or be required to apply to a particular bill.
- Hospitals that do not offer a self-pay rate may display the hospital’s undiscounted gross charge as found in the chargemaster



# Definitions (Continued)

## De-identified Maximum and Minimum Negotiated Charges

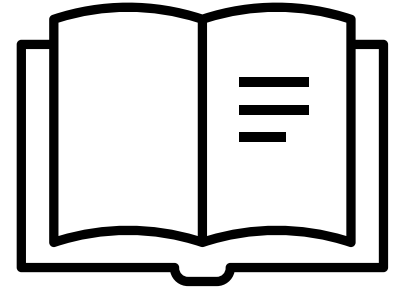
- The highest and lowest charges that a hospital has negotiated with all third party payers for an item or service.



# Definitions (Continued)

## Items and Services

- All items and services provided by a hospital in both the inpatient and outpatient setting.
- The definition includes facility fees, physician and other professional charges ***if the professional is employed by the hospital***, supplies, procedures, and room and board.
- In addition, CMS requires hospitals to include all “service packages,” i.e., any form of bundling charges, such as a per diem rate or a diagnosis-related group rate, negotiated with payers.



# Posting Standard Charge Information

- ***Each hospital location*** is required to post a single, machine-readable file (XLM or CSV file) with a standard set of data elements, including:
  - A description of each item or service (both individual items/services and service packages);
  - The corresponding gross charge, payer-specific negotiated charge (clearly identifying the name of the third party payer and plan), de-identified maximum and minimum negotiated charge, and discounted cash price; and any hospital accounting or billing codes.
- Hospitals are required to post the file on a prominent place on their websites without requiring any form of patient registration or other “barrier” to access.
- The file needs to be updated at least annually and clearly indicate the date of the last update.
- Must use a CMS-specified naming convention for its file:  
<ein>\_<hospitalname>\_standardcharges.[json|xml|csv].



# Hospital Price Transparency Frequently Asked Questions (FAQs)

<https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf>

<b>Item/service description</b>	<b>Billing Code</b>	<b>Gross Charges</b>	<b>Payer 1 negotiated charge</b>	<b>Payer 2 negotiated charge</b>	<b>Payer 3 negotiated charge</b>
CT scan	[if applicable, for example, CPT or HCPCS]	\$250	\$125	N/A	N/A
Hospital inpatient care – per diem (daily) rate	[if applicable]	N/A	N/A	\$500	N/A
Joint replacement	[if applicable, for example, DRG]	N/A	N/A	N/A	\$15,000

# Display of 300 “Shoppable” Services

- In addition to a machine-readable file, hospitals must post standard charge information for 300 “shoppable” services in a consumer-friendly way that is both easily understood and searchable
  - **Shoppable Services:** services that can be scheduled in advance.
  - **Standard Charge Information:** payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices.
- For the shoppable services that include ancillary services, hospitals are also required to display the same standard charge information for the ancillary services.
  - **Ancillary Services:** items and services a hospital customarily provides as part of or in conjunction with a shoppable primary service, such as laboratory, radiology, drugs, delivery room, operating room, therapy (physical, speech, occupational), hospital fees, room and board charges and charges for employed professional services.



# Display of 300 “Shoppable” Services (Continued)

- CMS has [defined 70 shoppable services](#) that hospitals must post.
  - (see pages 65571-65572 of above link)
- Hospitals must identify the remaining 230 shoppable services based on common services for the populations they serve.
- In the final rule, CMS noted its intention to increase the number of required shoppable services over time.



# Display of 300 “Shoppable” Services (Continued)

- For each shoppable service, CMS requires hospitals to display:
  1. A plain-language description of the shoppable service;
  2. An indicator when one or more of the CMS-specified services is not offered by the hospital;
  3. The payer-specific negotiated charge that applies to each shoppable service and each ancillary service and the third party payer and plan;
  4. The discounted cash price;
  5. The de-identified minimum and maximum negotiated charges;
  6. The service location, including whether the charges apply to an inpatient setting, outpatient setting, or both; and
  7. Any primary accounting or billing code (e.g., DRG, CPT, HCPCS).
- Hospitals have some leeway on the format and location of the display, as long as it is easy to access, publicly available without any barriers and searchable by service description, billing code and payer.
- Hospitals can use an interactive online tool or, as CMS notes, a “low-tech and inexpensive way” by creating and posting consumer-friendly files.



# Display of 300 “Shoppable” Services (Continued)

## Price Estimators

- Hospitals can meet the shoppable services requirement by voluntarily offering an internet-based price estimator tool that:
  - Provides an estimate for at least 300 shoppable services, including for as many as the 70 CMS-specified services as are offered at the hospital;
  - Allows consumers to obtain an estimate of their expected out-of-pocket costs at the time of using the tool; and
  - Is displayed prominently on the hospital’s website and accessible to the public without charge or having to register or establish a user account or password.
- *See the page 12 of the [CMS FAQ](#) for more information.*



# Sources on Price Transparency

- [CMS FAQ](#)
- [CMS Price Transparency Website](#)
- [American Hospital Association Regulatory Advisory](#)
- [AHA Price Transparency Infographic](#)
- [CMS Price Hospital Price Transparency Rule](#)
- [Health Plan Price Transparency Rule](#)



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# The No Surprises Act

- On Dec. 27, 2020, the No Surprises Act was signed into law as part of the [Consolidated Appropriations Act of 2021](#)
- Effective January 1, 2022
- Applies to individual and group health plans, including fully insured plans sold through the individual and groups markets, as well as self-funded plans (“ERISA” plans)



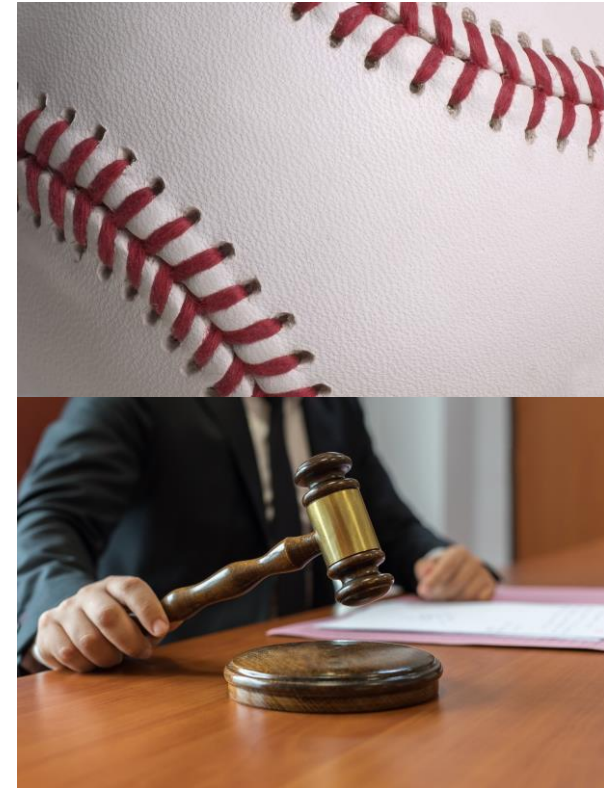
# Overview

- Beginning Jan. 1, 2022, out-of-network health care providers (including facilities) may not balance bill patients for:
  - covered emergency services or
  - 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.
- Sets up an independent dispute resolution process for providers and payers.
- Beginning Jan. 1, 2022, out-of-network air ambulance providers are prohibited from sending patients balance bills for more than the in-network cost-sharing amount



# Dispute Resolution Mechanism

1. The provider may accept or reject the plan's initial payment.
2. The health plan and provider may enter negotiating procedures during a 30-day period beginning the day the provider receives the initial payment (or denial) from the plan.
3. If there is no resolution, within 4 days of the end of the initial 30-day period, the parties may bring an outstanding dispute to a new independent dispute resolution process.
  - Within 10 days of selecting an IDR entity, each party must submit an offer for reimbursement, as well as any supporting materials.
  - Within 30 days of being selected, the IDR entity must select one of the offers without modification as the final reimbursement determination.
  - *However, the parties can continue to negotiate during the IDR process and do not need to complete it if they can agree to reimbursement during this period.*
  - *Providers may batch together like claims attributable to the same health plan that occur during a 30-day period.*
  - *"Loser pays" rule*



# Independent Dispute Resolution Factors

## Arbitrators must consider:

- The qualifying payment amount for the item or service.

## Arbitrators may consider (and must if requested by either party):

- The level of training, experience, quality and outcomes of the provider;
- The market share held by the provider and the health plan;
- The acuity of the patient;
- The teaching status, case mix, and scope of services of the provider;
- Demonstrations of good faith efforts (or lack of efforts) to enter into a network agreement with the other party; and
- if applicable, past contracted rates between the parties during the previous four years.

## Arbitrators may not consider:

- Billed charges; or
- rates paid by public programs (like Medicare or Medicaid).



# Patient Cost Sharing

- This is really confusing, so bear with us.
- The percentage of the patient's in-network cost sharing governs.
- So, if a patient owes 10% on in-network, emergency care, then the patient owes 10% on out-of-network emergency care.
  - Question: 10% of what?
  - Answer: 10% of the **recognized amount**.



# The Recognized Amount

**The recognized amount:** the amount set by a state surprise billing law.

If no state surprise billing law amount, then the recognized amount set by a state's all-payer claims database.

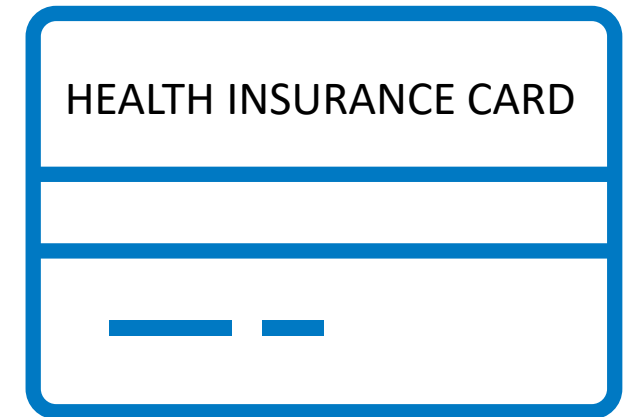
If neither applies, then the recognized amount is the **qualifying payment amount:**

- Initially, the health plan's median contract rate on Jan. 31, 2019 within the same insurance market.
- However, by July 1, 2021, HHS is required to set the qualified amount.



# Health Plans

- Health plans must include the following new information on insurance identification cards for plan years beginning on or after Jan. 1, 2022:
  - All plan deductibles, including in-network and out-of-network deductible amounts, as applicable;
  - Maximum limits on out-of-pocket costs; and
  - A telephone number and web address for consumer assistance information, including information on in-network providers.



# Data Call

- Beginning in 2022, HHS must post information on:
  - The number of IDR requests;
  - The size of the provider practices or facilities submitting requests;
  - The number of cases that actually went before an arbitrator;
  - A description of the item or service;
  - The geographic location where the item or service was delivered;
  - The amount each party offered through the IDR process;
  - Which offer was selected;
  - The identity of the parties;
  - The category and practice specialty of the provider or facility;
  - The length of time it took the arbitrator to make a determination;
  - The compensation paid to the IDR entity;
  - The amount HHS has expended to carry out the IDR process;
  - and other information as specified by the HHS Secretary.



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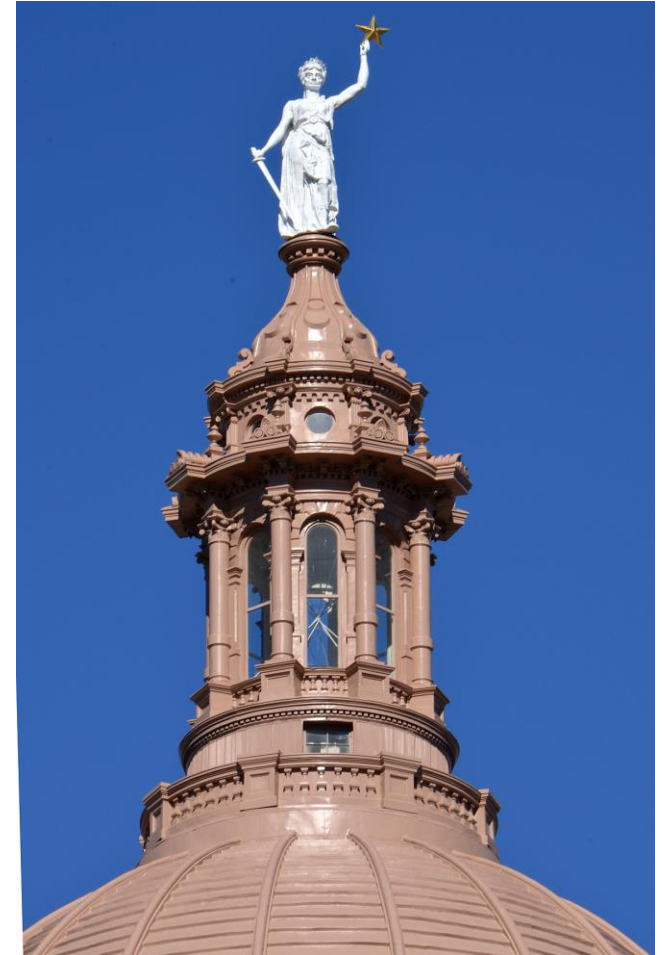
# Price Transparency and the 87<sup>th</sup> Session

- State Law Codification of Federal Price Transparency Rule
  - [House Bill 2487](#) (Rep. Oliverson) / [Senate Bill 914](#) (Sen. Hancock) / [Senate Bill 1137](#) (Sen. Kolkhorst)
- [House Bill 1490](#) (Rep. Dean): Requires a hospital to disclose cash prices
- [House Bill 2090](#) (Rep. Burrows): Requires health plans to disclose negotiated rates and other information to consumers (codification of related federal rule that applies to health plans)
- [House Bill 1907](#) (Rep. Walle): Requires an all claims payor database at U.T. Health Science Center Houston



# SB 1264, 86th R.S.

- **Effective Jan. 1, 2020**, SB 1264 prohibits out-of-network balance bills and creates a dispute resolution process for:
  1. Out of Network Emergency Care (facility's bill or provider's bill);
  2. 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
  3. 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.



**NOTE:** THE BILL ONLY APPLIES TO PLANS REGULATED BY TDI WHICH IS ABOUT 16 PERCENT OF TEXANS



# SB 1264: Bifurcated Dispute Resolution

## Facilities

### Open-Ended Mediation

#### Parameters

Whether the amount charged by the provider is excessive or the amount paid by the health benefit plan issuer is the usual and customary rate or is unreasonably low

## Non-Facility Providers:

### Baseball-Style Arbitration

#### Parameters

Using mandatory factors, arbitrator chooses between either the out of-network provider's best offer or the amount paid by the payer, as amounts were last modified.

TDI selects an organization (Fair Health) to maintain a benchmarking database for each geozip area to calculate the 80th percentile of billed charges and the 50th percentile of rates paid to participating providers.



# List of Texas Mandatory Arbitration Factors

1. Whether there is a gross disparity between the fee charged by the out-of-network provider and:
  - a) fees paid to the out-of-network provider for the same services rendered by the provider to other enrollees for which the provider is an out-of-network provider; and
  - b) fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services in the same region;
2. The level of training, education and experience of the out-of-network provider;
3. The out-of-network provider's usual billed charge for comparable out-of-network services;
4. The circumstances and complexity of the enrollee's particular case, including the time/place of the service;
5. Individual enrollee characteristics;
6. The 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database;
7. The 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database;
8. The history of network contracting between the parties;
9. Historical data for the percentiles described by subdivisions (6) and (7); and
10. an offer made during the informal settlement teleconference.

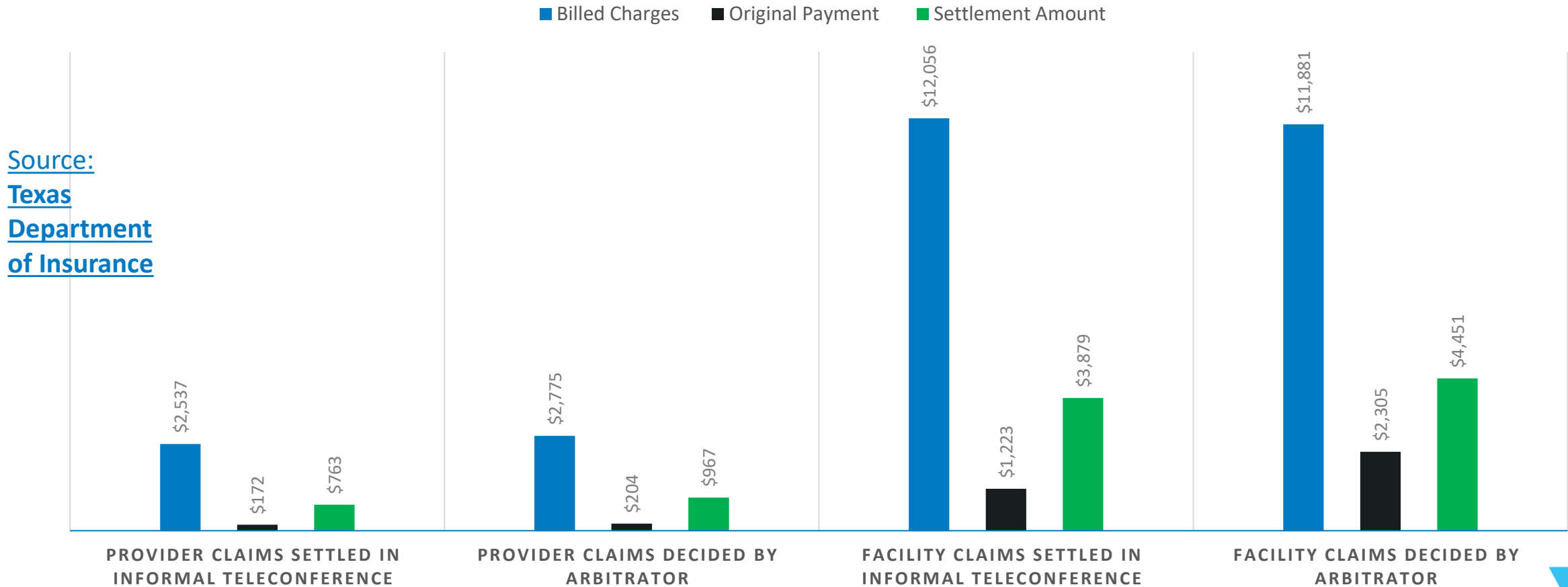


# Texas Data on Mediation and Arbitration

JANUARY 1 THROUGH OCTOBER 31, 2020 TDI DATA

ARBITRATION REQUESTS: 32,036

MEDIATION REQUESTS: 1,799



# Sources on Surprise Billing

- [The No Surprises Act](#)
- [American Hospital Association Detailed Summary of No Surprises Act](#)
- [American Medical Association High-Level Summary of the No Surprises Act](#)



# Questions

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