Compliance and Risk Reduction

# Price Transparency

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# Leaning Objectives

A. Understand basis and support for federal price transparency and surprise billing requirements;

B. Identify strategies to monitor compliance and reduce enforcement risks;

C. Learn about where the transparency trend is headed, including discussion of litigation challenging federal requirements

# Agenda

- How did we get here?
- The current requirements
- Monitoring Compliance
- Next Steps in Price Transparency

# How did we get here?

# Statistics

- HHS: 66.5 percent of all bankruptcies were tied to medical issues.
  - "Medical issues," for this purpose, include high costs of health care ***or time out of work***.
- HealthAffairs study (2017): large percentage of hospital visits result in a bill from an out-of-network provider, commonly referred to as a "surprise bill"*:
  - 20% of hospital inpatient admissions that originated in the emergency department (ED)
  - 14% of outpatient visits to the ED
  - 9% of ELECTIVE inpatient procedures
    - * It has become common to use the term "surprise bill" to refer to any out-of-network bill even if the patient consented to the use of an out-of-network provider through the provider's standard disclosure agreements.

# Minnesota leading the way

- Minnesota Attorney General Agreement
  - Signed by all Minnesota hospitals in 2007, renewed multiple times
  - Requirements
    - Charity care policies and requirements
    - “Most Favored Insurer” rate for the uninsured
    - Limits on debt collection activity
- Good-faith estimate law (Minn. St. § 62J.81) – first adopted in 2004
  - Providers required to “estimate the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer …”
  - For consumers without insurance, the provider must estimate
    - “the average allowable reimbursement the provider accepts as payment from private third-party payers …” and
    - “the estimated amount the noncovered consumer will be required to pay.”

# State Responses (cont.)

- Minnesota Surprise Billing Law (Minn. St. § 62Q.556) (2017)
  - Hold harmless for patients
  - Provider/Insurer dispute resolution process
  - Does not apply to emergency services or self-funded health plans
- Primary Care Price Transparency law (Minn. St. § 62J.812) (2018)
  - Providers to post 25 most frequently billing CPT codes over $25
- Minnesota was/is not alone – many states adopted measures to promote transparency

# Initial Federal Efforts

- Internal Revenue Code 501(r)
  - Affordable Care Act required IRS to develop charity care and charge limits for non-profit hospitals and health systems
  - Requires hospital to create a Financial Assistance Policy (FAP)
  - Limits charges to FAP-eligible patients to the Amounts Generally Billed (AGB) (calculated based on payments from most payers)
  - Imposes restrictions on billing and collection activities
  - Cite:  79 FR 78953

# Initial Federal Efforts

- Hospitals required to publish a list of their "standard charges." (42 U.S.C. § 300gg-18(e))
  - Old HHS definition of standards charges:
    - A standard list of all the billable services accounting for the cost of providing the service, other fees, and equipment needs
    - Essentially the chargemaster
  - The chargemaster price "is not what anybody pays …"
    - Medicare sets its own rate, not included in the chargemaster
    - Payers negotiate discounts, either from the chargemaster rate or, more commonly now, prices are set through negotiation
    - Uninsured and under-insured patients are entitled to legal discounts (see, e.g., the Minnesota Attorney General Agreement) or eligible for discounts or charity care
      - Maybe if you are a Saudi Prince you may pay the chargemaster rate

# The current requirements

# Outline

- Balance Billing Limits (42 U.S.C.A. § 300gg-131)
- Hospital Price Transparency (84 FR 65524)
- Payer disclosure obligations (86 FR 36872)

# New Federal Law and Regulations

- The No Surprises Act was part of the Consolidated Appropriations Act of 2021
  - Contained a number of new requirements for providers and health plans related to price transparency, most notably a national “surprise billing” solution that bans certain balance billing
    - Patient hold harmless
    - Dispute resolution for payers and providers
    - No rigid formula for rates – n benchmark rate and Medicare/Medicaid based percentage
- New Federal Regulations expand the definition of “standard charges” and expand the scope of who must make disclosures:
  - New rules for hospitals
    - Federal rule issued November 27, 2019. Cite: 84 FR 65524
    - Finally took effect January 1, 2021
  - New rules for payers
    - Interim Final Rule (IFR) published July 13, 2021. Cite: 86 FR 36872
    - Health plan provisions mostly takes effect: January 1, 2022

# Balance Billing Limits – Who and What is Covered?

- Who is Covered?
  - A participant, beneficiary, or enrollee …
  - with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer …
  - furnished during a plan year beginning on or after January 1, 2022
- What is Covered?
  - Emergency services (for which benefits are provided under the plan or coverage) with respect to an emergency medical condition
  - Covers services provided at:
    - a nonparticipating facility, or
    - by a nonparticipating provider
  - Locations covered:
    - emergency department of a hospital, or
    - independent freestanding emergency department

# Balance Billing Limits – Consent

- Consent allowed for services by an out-of-network provider at an in-network facility (42 U.S.C.A. § 300gg-132) (subject to limits)
- Limits:
  - Appointment for services made 72 hours in advance
  - Written notice in paper or electronic form, as selected by the patient, in 15 most common languages
  - Clearly states that consent is optional and patient may receive the services from a participating provider at an in-network cost-sharing rate
  - Provide a list of participating providers who are able to provide the services (if any)
  - Provide a good-faith estimate of the amount that will be charged to the patient
  - Provides notice of prior authorization or other care management limitations that may apply
- No consent allowed for:
  - emergency services
  - Ancillary Services (Anesthesiology, Pathology, Radiology, Neonatology, lab services)

# Balance Billing Limits – Provider Disclosure

- Additional Disclosure requirements for providers
  - Providers must create a “one-page notice” outlining the federal balance billing requirements, any applicable state law requirements, and information on how to file a complaint with the federal or state government (42 U.S.C.A. § 300gg-133);
  - Provide a good-faith estimate of total expected charges (42 U.S.C.A. § 300gg-136); and
  - Provide details on Patient-Provider dispute resolution process for the uninsured individuals (300gg-137).

# Balance Billing Limits – Payer/Provider Negotiation

- Balance subject to negotiation/arbitration
  - Process:
    - Plan makes initial payment or denial,
    - Provider objects to payment amount,
    - negotiations occur,
    - if unresolved by negotiation subject to “Baseball style arbitration” (subject to certain factors)
  - Arbitration factors (300gg-111(c)(5)(C)):
    - Submitted offers from both parties,
    - training and expertise of the providers,
    - market share of the provider,
    - quality and outcomes
  - Factors that cannot be considered (300gg-111(c)(5)(D)):
    - Billed charges
    - usual and customary charges, or
    - public payor rates

# Balance Billing Limits – State Preemption

- State law preemption and deference:
  - state law is preempted if it “prevents the application” of the No Surprises Act
  - This is the same preemption standard used by HIPAA and ACA
  - Permits states to impose stricter requirements

# Hospital Price Transparency

- The Rule requires two hospital disclosures:
  - Disclose the “standard charge” for every “item or service” where a standard charge has been established in a “machine-readable” format
  - Provide a separate consumer-friendly list of 300 “Shoppable Services”
    - Alternative for Shoppable Services: Provide access to a “price estimator” that provides information for the CMS defined shoppable services plus at least 225 additional Shoppable Services

# Hospital Price Transparency – Machine Readable

- "Standard charge" defined:
  - Gross charges –
    - meaning the chargemaster price
  - Cash discount prices –
    - "generally applicable price the hospital would accept from a cash-paying customer"
  - The payer-specific negotiated charge, for every payer with whom the hospital has negotiated a price for the service
  - The de-identified maximum negotiated charge
  - The de-identified minimum negotiated charge

# Hospital Price Transparency – Machine Readable

- "Every 'item and service'" defined:
  - Includes any item, DRG, or "service package" where a price has been negotiated
  - Include facility fees, room and board, and other fees
  - Include costs of services from employed providers, but not contracted providers

# Hospital Price Transparency – Machine Readable

- Other requirements
  - Each hospital location must publish a list, unless a health system has a uniform rate
  - Each item needs a plain language description of service and a code
  - Display must be searchable
  - List must be public and not behind paywall, registration requirement, or require any information from the viewer
  - File must be updated at least annually.

# Hospital Price Transparency – “Shoppable Services”

- More detail on “shoppable services”
  - A service that can be scheduled in advance
  - Must post at least 300 services:
    - 70 services defined by CMS
    - 230 selected by the provider
  - Must be posted separately from the machine-readable list
  - Hospital must identify and group the ancillary services customarily provided as part of, or in conjunction with, each shoppable service
- Price Estimator Tool is an acceptable alternative
  - Must include all 70 CMS-specified services (if the hospital provides those services)
  - Prominent display on the website
  - Accessible without a charge to, or registration by, the consumer
  - Allows a consumer to estimate the amount they will be obligated to pay

# Payer disclosure obligations - Summary

- Interim Final Rule includes requirements related to:
  - patient cost-sharing protections,
  - notice and consent standards for waivers,
  - rules for calculating the qualifying payment amount (QPA),
  - disclosure requirements,
  - significant restrictions on Air Ambulance service charges. and
  - complaints processes.

# Payer disclosure obligations – Coverage and Limits

- Applies if the plan provides or covers any benefits for emergency services
- Prohibits the Plan from denying coverage based on prior authorization requirements, whether the provider is in-network, or any other term or condition
  - Exceptions: rule allows denial based on requirements related to coordination of benefits, or a permitted affiliation or waiting period.
- Limits consumer cost-sharing amounts for emergency services
  - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
  - If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law.
  - If neither of the above apply, the lesser amount of either the billed charge or the qualifying payment amount, which is generally the plan's or issuer's median contracted rate.

# Monitoring Compliance

# Risks of Non-compliance

- Financial penalties
  - Balance Billing:  If patient is sent a prohibited bill, Civil Money Penalties of up to $10,000 “per violation”
  - Price Transparency:  Current hospital penalty for non-compliance is $300 per hospital per day
- Poor patient/consumer relations
  - Extensive coverage of compliance (or non-compliance) in media
  - Consumer demand for information –
    - Will a patient choose a different provider based on the quality/volume of information disclosed?
- Always a risk of more significant enforcement

# Price Transparency Enforcement

- Complaint-Based – CMS has set up easy mechanism to submit a complaint
- CMS Enforcement letters – requiring a written hospital response within specified timeframe
- Additional Enforcement is coming:
  - Increased financial penalties
    - CMS proposed rule to increase daily penalties up to $5,500 per day large facilities
    - CMS also considering increased penalties for intentional or severe violations
  - False Claims Act enforcement/False Certification Liability
    - When submitting a claim, providers are certifying that they have complied with ancillary legal requirements
    - The circuit courts are divided on the extent to which the implied false certification theory can give rise to FCA liability.

# Areas of Enforcement Focus

- Are patients being balance billed or charged higher cost-sharing than appropriate?
  - Are providers sending inappropriate bills to collection?
- Price Transparency
  - Are the posted prices the actual contract price (excluding value-based purchasing discounts)?
  - Is the data being reported current?
  - How difficult is it for the public to access the information?
    - Is it easily findable from the hospital website?
    - Is the hospital publishing it in a format that blocks it from being included in search engine searches?
    - Are there unreasonable service interruptions, off-line periods?

# Next Steps in Price Transparency

# Litigation Challenges

- Hospital and Insurance Company industry groups challenged the rules in federal court
  - The government rules survived the legal challenge. *American Hospital Association v. Azar*, 983 F.3rd 528 (D.C. Circ. 2020)

# Continued Challenges for Providers

- Substantial price variation
  - Sites of service
  - Comparing one geographic region to another
  - Substantial variation on services within a market are hard to explain
- Patients are often unaware of existing price transparency tools or do not use them; Policy-makers have only slightly more awareness than the general public
- Price transparency only provides part of the story to patients
  - Patient share of price is confusing
  - High-deductible plans, coverage limits, out-of-pocket limits
- Does promoting price comparison result in decline in focus on quality of care?
- Media, medical bill of the month, “Why I’m Obsessed with Patients’ Medical Bills”

# Questions/Comments

# For more information

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