



COMPLIANCE SERVICES Alert



Dec. 4, 2019

Through the glass a bit less darkly: Feds finalize transparency rules for hospitals, propose them for health plans

The Trump administration has issued regulations designed to make the cost of healthcare more transparent for patients, ideally empowering them to shop for care yielding a bigger bang for their healthcare dollars. Interestingly and highly controversially, the rules would require disclosure of even discounted, *negotiated payment rates* between health plans, health insurers and in-network healthcare providers like hospitals and doctors.

The administration issued *two* sets of regulations. The most provocative of these for group plan sponsors are *proposed* rules requiring nongrandfathered (under the Affordable Care Act) health plans to disclose two broad categories of information:

1. An insured's out-of-pocket cost sharing for a particular healthcare service, taking into account the portion of the insured's deductible and out-of-pocket maximum satisfied to date.
2. The amount the plan will pay for a wide variety of healthcare services provided by *different in-network providers in various locations*, and an estimate of what it would pay for out-of-network care, based on recent payments of similar out-of-network claims.

The proposed rules would pose significant technology challenges for plans and their vendors, by requiring such cost and payment information (updated monthly) to be available online. Further, patients would need to be able to readily search the data for various healthcare services and determine what they and the plan would pay for those services. The proposed rules, if finalized next year, would come online for calendar year plans in 2022.

The second set of rules are *final* regulations requiring *hospitals* to disclose, and make available to the public, their retail charges, negotiated (i.e., in-network) charges, and the cash discount price for the services they provide, in addition to other pricing information. These rules take effect in 2021, but are already drawing fire in the form of legal challenges.

We explore both sets of rules below, and in a webcast scheduled for Jan. 14, 2020, at 2 p.m. CDT. Click to [register](#) for the webcast.

A closer look: the proposed rules for health plans

As noted above, the proposed rules would require nongrandfathered health plans to disclose to a participant, beneficiary or other enrollee (or their authorized representative), detailed cost-sharing information, including an estimate of such individual's liability for covered items or services furnished by a provider.

The plans would also be required to make such information available on an internet website and, if requested, through non-internet means, allowing individuals to obtain an estimate and understanding of their out-of-pocket expenses and effectively shop for medical items and services.

Lockton comment: Much, or at least some, of this information is already available to plan sponsors and the enrollees in their health plans. The main differences under the proposal are that the cost-sharing information would have to be available *prior* to the services being rendered.

The proposed rules would also require plans to disclose negotiated rates for in-network providers and, for individuals considering using an out-of-network provider, a historical summary of out-of-network allowed amounts.

The rules would require this information to be available through two machine-readable files posted on an internet website, thereby allowing *the public* to have access to the plans' health insurance benefit information. The default method of making the information available would be via an "Internet-based self-service tool." The self-service tool would have to be available in plain language, with no fee, in real time and accurate at the time of the request.

Lockton comment: Several of the provisions in the proposed rules include the qualifier that the information supplied by the plan be accurate *at the time of the request*. That qualifier is a double-edged sword: Plans can rely on it as a shield, where cost information changes between the time an individual first makes inquiry and the time the individual receives the relevant care. But it also requires plans to ensure that, at the time of the request, the plans' internet tools have accurate, up-to-date information, particularly about charges that would be made by various providers. *That* strikes us as a challenge.

The same information must also be made available via paper upon request without any fee and be mailed to the participant within two business days after any such request is received. Health plans may provide consumers the option to receive the information through other methods, such as by phone, face-to-face, facsimile or email.

Lockton comment: The disclosure rules will look overwhelming to many employers. Although we expect their plans' third-party claims administrators and/or insurance carriers would quickly gear up to provide the required information, the *plan sponsor* will not only end up paying for the effort, but would have the ultimate responsibility for ensuring that the disclosure requirements are met with respect to their plans, unless (with respect to insured plans) the insurer is willing to accept that responsibility in writing.

What should plan sponsors do now? Wait and see. The rules are not likely to be finalized with an effective date before 2022 and will almost certainly spawn legal challenges from multiple stakeholders. Thus, there

will be adequate time to have the necessary discussions with insurance carriers, third-party claim payers and other vendors regarding who will provide the necessary information, and to amend service agreements and their indemnity provisions accordingly.

A closer look: The *final* rules for hospitals

While of only *indirect* relevance to group medical plan sponsors, federal regulators have also finalized rules requiring most hospitals, beginning just 13 months from now, to make readily available to the public several categories of charges for hundreds of items and services they provide.

Lockton comment: The disclosure rules do not apply to federally owned or operated hospitals, or hospitals operated by an Indian Health Program.

The rules require hospitals to post publicly online their “standard charges” for all items and services in connection with inpatient stays and outpatient visits. “Standard charges” include the following:

- The “chargemaster price” (essentially, the retail charge, or the starting point for negotiations between the hospital and its patients and their payers, like insurance companies).
- Negotiated prices with various payers, like insurers and other networks; the information must be payer-specific.
- The minimum and maximum charges the hospital has made for the items and services.
- The discounted cash price, for individuals paying in cash.

If the hospital operates in several locations, and different locations apply different standard charges, each location must identify its standard charges

The rules also require hospitals to make publicly available, “in a consumer-friendly manner,” their standard charges for a federally defined list of 70 “shoppable services,” or services a patient can schedule in advance. Hospitals must then supplement the list of 70 with at least 230 other shoppable services, for a list totaling at least 300 services.

The list of shoppable services must include:

- A plain-language description of the services
- The negotiated charge payable to specific third-party payers, like insurance companies
- The location where the service is provided, and
- Any code used by the hospital for accounting or billing purposes, including CPT, HCPCS, DRG or NDC identifiers.

While hospitals have some flexibility regarding how to disclose this information, they must do so via an “appropriate publicly available Internet location,” and the information must be readily accessible without fee and without having to establish a user account or password.

Lockton comment: The concept is that an individual should be able to go to the internet and search a particular hospital at a particular location to determine the various standard charge components (retail, in-network, out-of-network, cash discount price) assessed by that hospital for all the relevant items and services, searching at the user’s discretion by service, billing code and/or payer (e.g., a given insurance company or network).

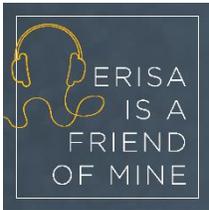
Although hospitals can be fined for noncompliance, the fine is extremely modest, particularly for large hospital systems. The maximum penalty is \$300 per day, regardless of the number of discrete violations of the rule.

Lockton comment: The maximum annual fine payable by a hospital for an unlimited number of violations thus appears to be \$109,500. We suspect more than a few hospitals, unless anticipating a competitive disadvantage by not playing by the newly final rules, will weigh the cost of compliance against the potential penalty before deciding to comply.

The final rules are highly controversial. As this *Alert* went to press three large hospital associations and several individual hospitals filed suit against the government, seeking to permanently quash the rules. That litigation may well delay implementation of the rules well beyond the intended 2021 effective date, if the rules survive at all.

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