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Special Bulletin

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Administration Issues Two Rules on Disclosure of Hospital and Health Plan Negotiated Rates

AHA, others set to take legal action on final rule

The Administration today released a final rule requiring hospitals to disclose payer-specific negotiated rates, along with a proposed rule that would impose new requirements on private insurers in the individual and group markets to publicly disclose negotiated rates and out-of-network allowed amounts, and give their enrollees real-time, personalized access to cost-sharing information.

Specifically, the Centers for Medicare & Medicaid Services' (CMS) final rule will require hospitals to post a list of five types of standard charges – now defined as gross charges, payer-specific negotiated rates, the de-identified minimum and maximum negotiated rates and discounted cash price – for all items and services in a machine-readable format on their websites. In addition to the machine-readable file, CMS will require hospitals to post the negotiated rates, minimum and maximum negotiated rates, and discounted cash price for 300 "shoppable" services in a consumer-friendly way that is both easily understood and searchable. CMS also finalized a process for monitoring and enforcing compliance, including civil monetary penalties. The effective date of the final rule is Jan. 1, 2021.

Key Takeaways

- CMS finalized a policy requiring hospitals to disclose their payer-specific negotiated rates. Hospitals will be required to release these rates for all items and services, as well as provide payer-specific rates for up to 300 "shoppable" bundles of services in a consumer-friendly format.
- CMS also will require hospitals to publish their de-identified minimum and maximum negotiated rates, as well as their discounted cash prices.
- This policy goes into effect Jan. 1, 2021.
- The government proposed 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.
- Health plans also would be required to provide personalized out-of-pocket cost estimates for all covered services to their enrollees.

AHA Take: In a joint statement with other national hospital groups, AHA said the final rule is a "setback in efforts to provide patients with the most relevant information they need to make informed decisions about their care. Instead of helping patients know their out-of-pocket costs, this rule will introduce widespread confusion, accelerate anticompetitive behavior among health insurers, and stymie innovations in value-based care delivery. America's hospitals and health systems have repeatedly urged CMS to work with hospitals, doctors, insurers, patients, and other stakeholders to identify solutions to provide patients with the information they need to make informed health care decisions and know what their expected out-of-pocket costs will be. We continue to stand ready to work with CMS to achieve this goal.

"Because the final rule does not achieve the goal of providing patients with out-of-pocket cost information, and instead threatens to confuse patients, our four organizations will soon join with member hospitals to file a legal challenge to the rule on grounds including that it exceeds the Administration's authority."

Highlights of the two rules rule follow.

HIGHLIGHTS

Hospital Disclosure of Negotiated Rates (Final Rule): The final rule purports to implement Section 2718(e) of the Public Health Services Act, which requires hospitals to make their standard charges publicly available. The rule establishes numerous specific requirements in regulation for the first time.

Definitions. In the rule, CMS finalizes the definitions of several terms, such as "standard charge," "hospital," and "items and services."

- CMS defines "standard charge" as both gross charges and payer-specific negotiated rates (referred to in the rule as "payer-specific negotiated *charges*"), as it had proposed. In addition, the final rule added three new definitions of standard charges: the de-identified minimum and maximum negotiated rates, as well as the discounted cash price.
- CMS defines "hospital" to mean all locations, including outpatient departments, of organizations licensed by a state (or local law as applicable) as a hospital and that serves the general public, including critical access hospitals, inpatient psychiatric facilities and inpatient rehabilitation facilities.
- CMS defines "items and services" as all items and services provided by a hospital, including facility fees, physician and other professional charges if the professional is employed by the hospital, supplies, procedures, and room and board.

Publication of Negotiated Rates. Beginning Jan. 1, 2021, CMS will require hospitals to post a list of all of their standard charges – including the gross charges, negotiated rates, de-identified minimum and maximum negotiated rates, and discounted cash price – for all items and services in a machine-readable format on their websites. Hospitals will be required to create a single, machine readable file with a standard set of data elements, including all forms of standard charges, a description of each item or service, and any hospital accounting codes and revenue codes, as applicable. Hospitals will need to post the file on a prominent place on their websites without requiring any form of patient registration or other "barrier" to access.

In addition, CMS will require hospitals to post the negotiated rates, de-identified minimum and maximum negotiated rates, and the discounted cash price for 300 "shoppable" services, both inpatient and outpatient, in a consumer-friendly way that is both easily understood and searchable. CMS defines "shoppable" as services that are non-urgent, routinely provided and can be scheduled in advance. Hospitals also will need to make available the same information for services that a hospital customarily provides in conjunction with the primary service.

CMS identified 70 services that hospitals will need to include across the categories of evaluation and management, laboratory and pathology, radiology, and medicine and surgery. These services range from a basic metabolic panel to a CT scan to removing a child's tonsils. Hospitals will need to identify the remaining 230 shoppable services based on common services for the populations they serve. CMS provides some flexibility

for hospitals to choose services other than the 70 identified by CMS, if, for example, the hospital does not provide some of the identified services. However, all hospitals will be required to post bundled charge data for at least 300 shoppable services.

CMS added a provision in the final rule that would exempt certain hospitals that have established out-of-pocket cost estimator tools from complying with this section of the rule. As long as the tools are publicly available and provide estimates for at least 300 shoppable services, including the 70 required shoppable services (if provided by the hospital), these hospitals will be deemed compliant.

Monitoring and Enforcement. CMS will monitor compliance through review of complaints and audits of hospitals' websites. In the case of noncompliance, CMS will first issue a warning and, if the violation continues, will require hospitals to submit and follow a corrective action plan. If a hospital does not submit or adhere to the corrective action plan, CMS can impose a civil monetary penalty of up to $300 a day.

Health Plan Transparency in Coverage Policy (Proposed Rule): The proposed rule would impose new transparency requirements on non-grandfathered group health plans and issuers of non-grandfathered health insurance coverage in the individual and group markets.

Disclosure of Cost-Sharing Information to Enrollees. CMS and the departments of Treasury and Labor would require health plans to provide their enrollees personalized information on their cost-sharing liability. This would include the expected out-of-pocket costs for a covered service performed by a specific provider. In addition, health plans would need to provide the accumulated amount the enrollee has spent toward their deductible or out-of-pocket maximum, the negotiated rate (if it is used to determine the cost-sharing amount, e.g., in the case of coinsurance), the out-of-network allowed amount (for out-of-network providers), the list of items and services covered under the estimate concerning a bundled payment arrangement, a notice of prerequisites of coverage (e.g., prior authorization), when applicable, and a disclosure notice. This information would need to be available through a consumer-friendly internet-based tool, as well as in paper form upon request.

Public Disclosure of Negotiated Rates. The departments also propose to require health plans to publicly disclose their negotiated rates with in-network providers and historic payments of allowed amounts to out-of-network providers in standardized machine-readable files. The negotiated rate file would need to include the plan name, billing codes for covered services, and the negotiated rate for each in-network provider (associated with its National Provider Identification (NPI) number). The allowed amount file would be required to include the plan name, billing codes for all covered services, and the historical out-of-network allowed amounts for covered items and services associated with a provider's NPI.

Medical Loss Ratio Proposal. CMS also proposes to incentivize insurers to share savings with enrollees when they use "lower-cost, higher-value" providers. CMS would amend the medical loss ratio (MLR) calculation methodology to allow insurers to take credit for their "shared savings" payments to enrollees. CMS does not define "lower-cost, higher-value" in the proposed rule.

Additional Requests for Information. The rule also includes additional sections requesting more information on provider quality measurements and reporting in the commercial health plan market, including how this information could be incorporated into the price transparency proposal, and whether the information required to be disclosed in this rule should also be made available through an application programming interface (API).

Effective Date. The enrollee and public disclosure portions of the proposed rule would be effective starting with the first plan year that begins at least one year after the finalization of the rule. The MLR provision would be applicable beginning with the 2020 MLR reporting year.

NEXT STEPS

The AHA plans to take legal action to try to prevent the final rule requiring hospitals to disclose their negotiated rates from going in to effect. The departments will accept comments on the proposed health plan rule for 60 days after the rule is published in the Federal Register.

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