Background Information: NCHC Discussion on Health Care Price Transparency:

Background: We are pleased that you can join us on **February 4th** for a discussion on price transparency. The National Coalition on Health Care is dedicated to educating about and advocating for effective strategies that will advance health care affordability. In our recent letter to the Biden Administration, we identified five policy priorities that can promote affordability, including improving price and quality transparency and promoting integrated and value-based care models.

Objective: *NCHC staff will use the conversation as a basis for a memo to the Biden Administration on the policy and implementation of price transparency in health care.* To that end, we are pleased to be convening a small group of leading health care purchaser, plan, provider, and consumer voices and representatives to discuss transparency strategies that are most likely to succeed in promoting value while minimizing administrative burden, complexity and inequity in the system. We look forward to discussing the opportunities and challenges presented by these policy changes, how they might work in practice, and how administrative costs and complexity associated with price transparency implementation can be minimized.

Recent legislative and regulatory action: Below are some links to reports and studies that you may find useful for our upcoming discussion. In addition, we've included an appendix outlining recent Federal Health Care Price Transparency Laws and Regulations (as of January 28).

Using regulatory authority established in the Affordable Care Act, the Trump Administration promulgated two significant rules that are intended to catalyze greater price competition in health care markets and more informed decision-making by purchasers and consumers. In addition, at the end of 2020 Congress enacted the bipartisan No Surprises Act, included in the Consolidated Appropriations Act of 2021, which places more price transparency demands on both providers and health plans.

Helpful References Related to Price Transparency in Health Care

- Trump Administration Finalizes Transparency Rule for Health Insurers, by Katie Keith
- 10 Things to Expect from the New Hospital Price Transparency Rule, by Ehnes, et al.
- The Future of Drug Pricing Transparency, by Feldman, et al
- What the Trump Administration Gets Right About Hospital Transparency, by Neeraj Sood
- Unpacking the No Surprises Act: An Opportunity to Protect Millions, by Jack Hoadley, Katie Keith, and Kevin Lucia
- Brown ZY. Equilibrium effects of health care price information. Rev Econ Stat 2019;101:699-712

Appendix: Federal Health Care Price Transparency Laws and Regulations (January 2021)

Regulation and/or Statute	Entities Covered	Requirements	Effective Date; enforcement
Hospital Price Transparency (finalized at CMS-1717-F2) Statutory authority section 2718(e) of PHS Act (PPACA); adds new Part 180 to 45 CFR	Hospitals, defined as any state licensed institution, where state includes DC, PR, territories, etc (includes all Medicare-enrolled hospitals, but not federally-owned hospitals, ambulatory surgery centers (ASCs)	**Hospitals** must post publicly, at least annually, a list of standard charges for items and services, including for DRGs (supplies, procedures, room and board, facility fees, **employed** physician fees, i.e., employed professional charges); Defines and includes prices for "service packages" as well as individual items, inpatient & outpatient; Defines, requires posting of gross charges, payer-specific charges, cash price standard charge, de-identified min and max charges; Must post standardized data elements in machine-readable data sets, using CPT and other codes, in single digital file; Publicly display online a consumer-friendly list of standard charges for at least 300 "shoppable services", including 70 identified in reg, with similar data elements as larger list, grouped with typical ancillary services provided; provide related internet-based price estimator tool prominently displayed on website, without charge or registration	1/1/2021 CMS will take public complaints, conduct audits of hospital websites, take action if it finds noncompliance: Written warning; Corrective Action Plan (CAP); Civil Monetary Penalties (CMPs) daily max penalty of $300/day
Transparency in Coverage Final Rule (CMS-9915-F); statutory authority at Section 2715A of PHS Act (PPACA)	Group health plans (non-grandfathered) and health insurance issuers in both individual and group markets	**Plan**-specific disclosure obligations to plan enrollees, participants, beneficiaries personalized out-of-pocket info and negotiated rates for all covered services, including drugs, through internet based self-service tool and in paper upon request; An initial list of "shoppable services" must be available via online self-serve tool; **Plan** disclosure obligation to general public, including "consumers, researchers, employers, and third-party developers", publish 3 separate machine-readable files that include 1) detailed pricing information, including negotiated rates with in-network providers, 2) historical payments to and billed charges from OON providers 3) in-network negotiated rates and historical net prices for all covered drugs at pharmacy location level. Issuers may "share savings" with consumers who shop from lower-cost providers and take credit for such savings in medical loss ratio (MLR) reporting.	Shoppable services list (500 services determined by CMS) available for plan years beginning on or after 1/1/23. Negotiated rates for all items and services, along with OOP calculator, required for plan years beginning on or after 1/1/24. Files intended for public must be available in prescribed format and updated monthly for plan years beginning on or after 1/1/2022.

No Surprises Act (part of Consolidated Appropriations Act, 2021) regulations forthcoming in 2021	Transparency obligations on plans (ERISA and state regulated) and providers (facilities and facility-based; air ambulances) related to disclosing network participation and obtaining consent for OON care; updating network directories; providing cost estimates in advance; cost estimator tools HHS to post aggregate data; GAO to issue reports Also includes grant support for state All-Payer Claims Databases (APCDs), incentives for self-insured ERISA plans to submit data voluntarily and APCDs to establish standardized data submission formats;	Patients protected from certain out-of-network billing situations, with emergency services limited to in-network (IN) cost-sharing; certain non-emergency services limited to in-network cost-sharing unless required notice and consent met. Covered providers/services prohibited from balance billing. Patient not liable for more than IN cost share if relied on inaccurate provider directory; In advance of obtaining consent for out-of-network (OON) care, OON **covered facilities and facility-based providers** must provide in advance good faith estimate of charges, list of any providers at facility that are IN, info on prior auth or care management limits placed on care; **Providers** must post notices on website explaining protections, how to file a complaint; **Health plans** must post on website, put in explanation of benefits (EOBs), items & services for which balance billing prohibitions apply; Plans must put benefit info on enrollee ID cards, including deductibles, out-of-pocket max, plan help line for provider network status; "Advanced Explanation of Benefits" (AEOB) required from plan if provider notifies plan of scheduled service with "good faith estimated amount", or if patient requests prior to service; AEOB to include: 1) provider network status 2) good faith estimate from provider 3) good faith estimate of amount plan will pay and any enrollee cost-sharing 4) good faith estimates of size of enrollee deductible, OOP max as of date of notification 5) disclaimer stating if item/service is subject to medical mgmt 6) varous disclaimers; all of this info must be provided according to specified deadlines; By 1/1/2022, **providers** required to provide info within specified time to individual who schedules service or requests certain info, including: 1) inquire about plan or program enrollment 2) give good faith estimate of expected charges for services (including any services or items expected to be provided by another provider), with billing codes; if individual enrolled in plan and seeks to submit claim to plan; or if individual not enrolled in plan or not submitting claim to plan; notice to be given under specified tight timelines;	Most provisions effective 1/1/2022, with rulemaking required in 2021 Enforcement: states (no new resources for state enforcement); Federal backup enforcement Existing state laws for state regulated plans not pre-empted with respect to setting payment for OON providers

	requirements on APCDs	By 1/1/2022, providers and facilities must have in place processes to ensure timely provision of provider directory info to plan in support of Act; including termination of network agreement; Health **plans** must establish related verification processes and update provider directories at least once every 90 days; plans must have response protocol for enrollees who request info about network status of providers; plans must maintain on public website list of each provider with which it has contractual relationship; **Plans** must offer a price comparison tool and help by phone to allow enrollee to compare amount of cost-sharing enrollee would be responsible for paying for specific items or services by any participating provider; Prohibits "gag clauses" between plans and providers that restrict health plan from disclosing provider-specific price, cost, or quality data; "reasonable restrictions" may be placed on public disclosure; requires health plan brokers to disclose compensation; **Plans** must report plan-specific prescription drug, hospital spending information to DOL/HHS/IRS to support new drug pricing tools; Plans have separate reporting requirements to HHS/DOL/IRS for air ambulance services claims, amounts, locations, network status; to be used by HHS to compile public report	