NORTHEAST
BUSINESS GROUP ON HEALTH

Hospital Price Transparency Requirements and Employers *What You Need to Know*

Wednesday, November 3, 2021
12:00 - 1:00 PM

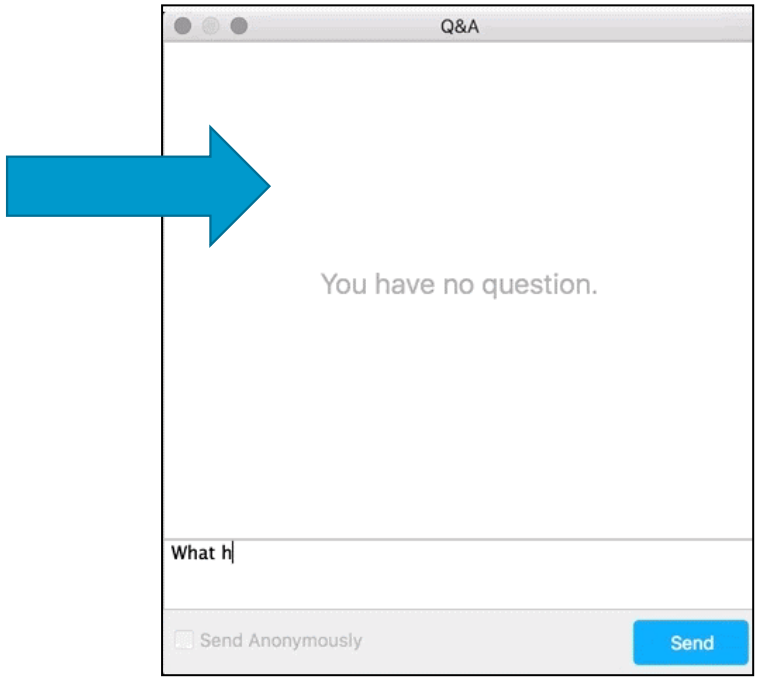
Webinar Procedures

All lines will be muted

Please submit all questions using the “Q&A” dialog box

Email Diane Engel at dengel@nebgh.org with any issues during this webinar

The recording and a PDF of the slides will be shared



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The Hospital Price Transparency Final Rule: Implications for Employers

"What You Need to Know"

November 3, 2021

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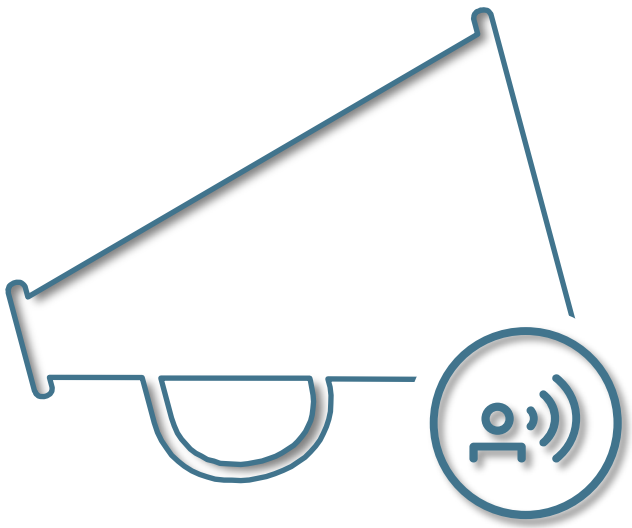
Agenda

- Overview of the Hospital Price Transparency Rule
- Compliance Challenges
- What are Employers' Responsibilities under the Hospital Price Transparency Rule?
- Protections for Employer Plan Sponsors
- Additional Notes on Enforcement

Overview of the Hospital Price Transparency Rule

- Outgrowth of Executive Order in 2019, directing HHS to create a regulation requiring hospitals to post both gross charges and payer-specific negotiated charges; in effect as of January 1, 2021
- Intent: Empower patients and constrain health care costs, encouraging (1) choice and (2) competition
- Expansive: Covers all health insurance providers, including commercial, Medicare Advantage, Medicaid managed care
- Note correlative Transparency in Coverage Rule to provide personalized information about consumers' out-of-pocket costs via on-line tool (effective July 2022)

Overview of the Hospital Price Transparency Rule

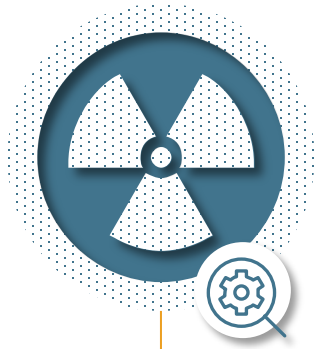


- The Rule requires most hospitals to post 2 types of information:
  - "Standard charges" for all items and services in a single digital file in machine-readable format on the hospital website of both (1) items and services and (2) service packages:
    - "Standard charges" means the regular rate established by the hospital for an item or service provided to a specific group of patients, including: gross charges, payer-specific negotiated rates, discounted cash price, de-identified minimum negotiated charge, de-identified maximum negotiated charge
  - Standard charges in a consumer-friendly, machine-readable format for 300 "shoppable services" that can be scheduled in advance: gross charges, discounted cash prices, payer-specific negotiated charges, de-identified minimum negotiated rates, and de-identified maximum negotiated rates
    - Requires high accessibility: no requirement to submit any personal identifying information to create an account, and no user fees
    - Annual updates

Compliance Challenges

- Hospital associations challenged the Rule in court in 2019, but lost: they claimed “lack of rational basis,” huge compliance burdens, lack of statutory authority for Rule, and undermining of their negotiating leverage with hospitals by mandatory revelation of confidential negotiating information
- Economists and others critical of Rule as not helpful to consumers: (1) not reflective of insured patients’ actual out-of-pocket costs, which are fact specific; (2) failing to include quality dimension; (3) redundant of cost-estimator tools already in use.

Compliance Challenges



- CMS has enforcement authority and may issue warnings, request corrective action plans, and/or impose civil monetary penalties.
- April: CMS began sending warning letters (165 as of July)
- July: CMS proposed an increase in penalties from $300 per hospital per day to $10 per bed per day for hospitals with 30 or more beds
- August: CMS stated it will not impose penalties at this time but will continue to send warning letters on a monthly basis
- American Hospital Association – “we are deeply concerned about the proposed increase in penalties for non-compliance, particularly in light of substantial uncertainty in the interpretation of the rules.”

Compliance Challenges

- *Health Affairs*: Hilltop Institute found 65 of 100 largest hospitals in U.S. were "unambiguously noncompliant"; 82% did not properly post payer-specific negotiated rates (Jan-Feb data)
- Milliman: Audited 55 health systems (over 600 hospitals); 32% did not post all required standard charges; only 2% posted nothing; many "challenges" with form and format of posted files (Jan-Mar data)
- Patient Rights Advocate.org – Audited random sample of 500 hospital websites; 94% not fully compliant (May-Jul data)
- *Wall Street Journal* – Some hospitals embedding code in their price transparency web pages that block them from appearing in searches

What are Employers' Responsibilities under Hospital Transparency Rule?

Summary: Employer plan sponsor must act prudently in selecting, contracting with and monitoring insurers and insurance contracts, or selecting administrators/advisers for self-funded plans

Employee benefits law governs: ERISA applies to both insured and self-funded plans, and imposes minimum standards and procedures on a plan's fiduciaries

Aims to encourage employers to set up and fund benefits

But even after ACA, our system doesn't require businesses to provide health benefits to their workers, though applicable large employers may face penalties for failure to make affordable coverage available

- Self-funded employers particularly have broad discretion with respect to the scope and design of benefits covered
- ERISA includes COBRA, HIPAA, the ACA, other group health plan provisions

Employers' Responsibilities under the Rule: Defining "Fiduciary"

Who's a "Fiduciary"?

- Dept. of Labor says most employers are if they sponsor fully or partially self-funded group health plans as they exercise some discretionary authority
- Fully insured plans: fiduciary status depends on whether the employer exercises discretion over the plan
- Plan administrators, investment managers, members of plans' administrative committee are ordinarily fiduciaries; TPAs or recordkeepers who perform solely "ministerial" tasks are not.

ERISA's code of conduct for fiduciaries: defines who has responsibility and liability for each aspect of plan administration and management:

Acting "solely in interest of the plan's participants and beneficiaries" and "for the exclusive purpose" of providing benefits and defraying reasonable expenses of administration

Paying only reasonable plan expenses

Fiduciary must discharge duties "with the care, skill, prudence and diligence under the circumstances…"

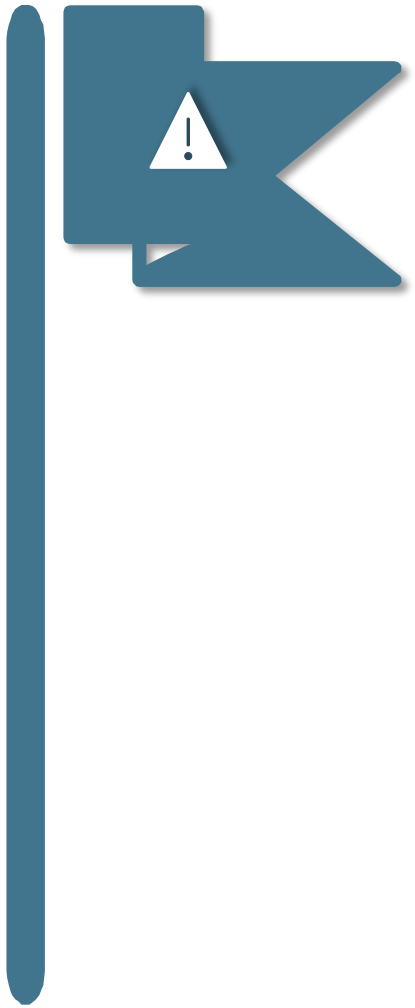
Protections for Employer Plan Sponsors: Choices May Not Involve "Fiduciary" Responsibilities

- Employer choices may not be covered by "fiduciary" rules:
  - Settlor functions: Employers are normally plan fiduciaries, but not treated as such when adopting, amending, or terminating an ERISA plan; so amending a plan, including changing options or deciding on plan content, is not a fiduciary function.
  - "Business decision" rule: negotiation and administration of service provider contracts not a fiduciary function
    - keeps publicly traded companies from being subject to dueling fiduciary duties (one to shareholders, and one to plan members)

Three Protections for Employer Plan Sponsors

- Protection #1: Prudent contracting and selection of service providers:
  - RFP process, perhaps with guidance of consultants; attention to both price and non-price dimensions
  - Auditing process
  - Ensuring required licenses, ratings, accreditation up to date
  - Reliance on third-party accreditation or certification
  - Guarantees in contracts
- Protection #2: Prudent monitoring of those service providers: Proper documentation of plan records:
  - Monitoring of reports
  - Monitoring of plan's benefits claims procedures
- Protection #3: Insurance and Indemnification:
  - ERISA doesn't allow fiduciary to relieve itself from responsibility for any fiduciary duty
  - But fiduciary can hire service providers (insurers, PBMs, TPAs, behavioral health specialists, etc.) to handle fiduciary functions, subject to monitoring
  - Plan can: (1) purchase insurance to protect itself against losses; or (2) enter into indemnification agreements that leave the fiduciary responsible, but permit another party like a TPA to satisfy the liability

Additional Notes on Enforcement



- Who would object to breach/violation of hospital transparency rule?
  - CMS: Rule provides for enforcement against hospitals
  - Dept. of Labor/EBSA
  - Consumers: Have right under ERISA to bring a court action to recover benefits, clarify rights, enjoin practices violating the plan terms, and to obtain equitable relief in federal court—less likely
- Could failure to take cost/quality of services available when selecting a plan or TPA constitute a fiduciary breach?
  - Quality: yes, says Dept. of Labor: cites “quality of services” to be considered by fiduciary when assessing an insurer or plan, including access to information concerning the qualifications of the medical providers and specialists, the operations of the health care provider, enrollee satisfaction, ratings and accreditation
  - Cost: tricky with hospitals because they are not pure substitutes for each other in terms of location, specialty, reputation; issue of ”must have” hospitals in network
  - Hospital Transparency Rule primarily concerns cost (as does Health Plan Rule)

Questions

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