

Talking Points on Final Price Transparency Rule – January 1, 2021

Key Points on Posted Files

- The information that hospitals will post as of January 1, 2021 is not what a patient will actually pay for that service and may only cause confusion. The posted information will be the hospital's expected third-party payer negotiated rate, which does not take into consideration the critical out-of-pocket-obligations individualized to a patient.
- Hospitals are working hard on developing tools for information related to what patients really want – their out-of-pocket obligation - which is dictated by their health plan.
- Hospitals and commercial health plans have negotiated payment rates for services that reflect myriad considerations and differing payment methodologies, resulting in variances across hospitals, even within the same health plan.
- The machine –readable file, which attempts to match third-party payment rates to each line of a hospital charge, cannot be used to compare prices among payers due to the different payment methodologies employed by payers. This means there cannot be an apples-to-apples comparison of negotiated payments across different payers.
- Information on a patient's out-of-pocket obligations is best provided by their health plan. This information is dependent on whether the plan covers the service, whether the provider is in or out of network, what the cost-sharing requirements are and where the patient is with meeting the deductible – all determined by the health plan they have.

Hospitals Support Transparency and Providing Estimates

- Illinois hospitals support price transparency policies that ensure patients have access to meaningful information about the cost of their care – most importantly, their out-of-pocket obligations. Illinois hospitals have dedicated financial counselors or financial clearance centers that are eager to help patients understand their financial obligations for services provided.
- They can assist in providing price estimates of a planned service, provide information on the hospital's generous financial assistance policy, provide information on health coverage that might be available through Medicaid or the Illinois ACA Marketplace (GetCoveredIllinois) as well as explain any billed services already provided.
- Illinois hospitals have generous financial assistance policies, including the Illinois Hospital Uninsured Patient Discount Act, which requires for eligible uninsured patients, either a 100% discount (free) or discounts to 135% of cost, depending on their income level. There is also a maximum collectible amount of 25% of annual family income.
- It's important for patients to understand that these prices and/or estimates may vary from the final bill they receive depending on the actual services that are provided due to medical condition, length of time spent in surgery or recovery, necessary specific equipment, supplies or medication, complications requiring unanticipated procedures, or other treatment ordered by the physician.
- Prices and/or estimates may also vary depending on the patient's health plan and what they will cover, whether the hospital or physician is in or out-of-network, meaning they

don't have a contract with the health plan, and whether the professional services provided by a physician, surgeon, radiologist, anesthesiologist, pathologist, advanced practice nurse or other independent practitioners are included as many are independent and not employed by the hospital.

CMS Final Rule Flaws

- The Centers for Medicare & Medicaid Services (CMS) requires that hospitals post two files on the internet by January 1, 2021:
 - a machine-readable file listing all items and services provided that includes gross charges, discounted cash prices, payer-specific negotiated charges, and de-identified minimum and maximum negotiated charges, by payer; and
 - a file for patient use that displays these negotiated charges for at least 300 “shoppable” services. Note that if hospitals have a price estimator available to patients on their website with all the required components, that price estimator satisfies this requirement.
- The machine-readable file will not be useful for patients as it lists every item individually that a hospital provides, not grouped into what would typically be a complete bill for a specific service. And this format is what is required by the rule.
- The third-party negotiated contracts will include variation in payment methods that can be a per diem, DRG, capitation, value-based components, outliers, additional payment for implants, percent of charges, etc.
- In nearly all cases, there is generally no direct correlation between line items contained in the chargemaster, a master list of gross charges representing all services and supplies, and the payment received for the total care of a patient. Depending on which payment method is used, that can even vary within one contract with one hospital, but for different services, so it will prevent an “apples to apples” comparison for patients. Furthermore, many governmental and commercial insurers use edits and payment grouping methodologies (i.e., ambulatory payment classifications/APCs) that again will not correlate to an individual Charge Description Master (CDM) line payment application.
- Some hospitals, such as Critical Access Hospitals, often have cost based payment contracts that pay an interim rate per day and then settle at the end of the year, so the payment is not attributable to any specific patient's services.
- A concern is that given the complexity of all the information outlined in the rule and the lack of specificity from CMS on numerous specific aspects of the files, the result will be inconsistent data, not helpful to understand what a patient would pay and that may just confuse patients.
- While the Trump administration could not have predicted COVID, it is unfortunate that during the worst health crisis in 100 years, hospitals must divert precious resources to comply with this requirement. We continue to press for a delay or modified implementation of this rule as the Biden administration steps in. Many hospitals will not have the internal resources to execute these rules, and will be forced to secure outside consultants, incurring even more cost during extraordinary times.

Hospital Pricing

- Illinois hospitals are required to provide estimates of the average charge for any procedure or operation a patient may be considering and post their chargemaster on their website. There is also an Illinois public website that lists all hospitals and what their average charge is for over 50 common diagnoses and procedures for comparison.
- However, the charge information hospitals provide is of limited value to the patient, because what most patients want to know is what they will have to pay for services they directly receive during a specific encounter.
- Federal law requires hospitals to set uniform charges as the starting point for all bills which is why a bill starts with charges, then deducts an amount related to either the allowable contractual adjustment required by Medicare or Medicaid or the negotiated discount with individual health plans. So hospitals are not paid charges by either patients or health plans.
- 92.8% of Illinoisans (Illinois Department of Insurance as of 11/19)¹ have third-party health coverage and their payer - Medicare, Medicaid, or commercial plan - sets the patient's out-of-pocket financial obligations.
- A patient's out-of-pocket amount is dependent on whether the plan covers the service, whether the provider is in or out of network, what the cost-sharing requirements are and where the patient is with meeting the deductible – all determined by the governmental plan in which they are enrolled or contract terms of their commercial health insurance company.
- Hospitals contract with hundreds of health insurance companies with many offering multiple plan types within one company.
- Hospitals negotiate prices with commercial health plans that reflect characteristics specific to that hospital that may differ from other hospitals. Hospital-specific characteristics that can influence negotiated rates include whether the hospital provides certain specialty services such as trauma or burn units, is affiliated with certain physician groups or other hospitals, is an academic medical center training physicians and other healthcare professionals, conducts medical research, treats higher number of low-income patients, market share or geographic region.
- For these reasons, the health plans are the best source of information as to what a specific patient will need to pay.
- The major health plans in Illinois have already created price estimators for their subscribers that provide what their financial obligation will be for specific services at specific hospitals.
- For the uninsured, all Illinois hospitals have generous financial assistance policies.
- A result of these generous charity policies is that over \$900 million in charity care at cost was provided by Illinois hospitals and health systems in 2018.
- There is sometimes a tendency to compare commercial vs. Medicare or Medicaid payment rates. However, Medicare and Medicaid rates do not cover the cost of providing care. In Illinois, average Medicare payments only cover 90% of the cost of providing care and Medicaid only covers between 75-80%. Without the ability to negotiate rates that help offset inadequate rates from public payers, patients will lose access to care.

¹ <https://www.statista.com/statistics/238747/health-insurance-status-of-the-total-population-of-illinois/#statisticContainer>