COST TRANSPARENCY: FEDERAL LAW, FEDERAL PROPOSALS, AND MARYLAND LAW

FEDERAL LAW AND PROPOSALS		
The Trump administration has made it a priority to end surprise billing and improve cost transparency in health care settings. On June 24, 2019, President Trump issued an Executive Order calling for agency action to promulgate new regulations regarding cost transparency. Congress also introduced legislation to address transparency in the health care billing space. These proposed bills include provisions regarding network transparency and ensuring beneficiaries know who is and is not in their provider network. Some of these proposals include requirements for notice and consent by the beneficiary prior to receiving out-of-network care. Some proposals also include provisions for civil monetary penalties and safe harbor periods when corrective action can be taken.		
	Medical Providers/Facilities	**Insurance Companies**
Affordable Care Act (ACA)	• Requires hospitals to publicly disclose standard charges for items and services. • CMS implementing regulations require hospitals to at least annually publicize standard charges online in an easily-understandable format. • Requirement by CMS for participation with Medicare/Medicaid • CMS currently does not recognize any exemptions to posting of standard charges.	• Requires insurers to provide a summary of benefits and coverage in plain language. • Must provide a glossary of health insurance terms.

STOP Surprise Medical Bills ACT of 2019*	• Must make known any financial profit-sharing relationship or profit-sharing agreement with any physician group.
	• Must provide within 48 hours of the beneficiary's request the expected enrollee cost-sharing for a service, including those reasonably expected to be provided in conjunction with the requested service.
		• Must notify in-network providers of new insurance products within seven days of issuance of the new product.
		• Insurance card should indicate in clear writing the amount of the in-network and out-of-network deductibles and any out-of-pocket maximums.
		• Must provide a good faith estimate of the cost of any elective health care service within 48 hours of the request, including services reasonably expected to be provided in conjunction with the requested service.
		• Must make out-of-pocket costs, benefit information, and provider network information available online.
		• Must provide to the Secretary of HHS total claims submitted by in-network and out-of-network providers. Out-of-network data must include:
		  ○ Amount of out-of-pocket costs
		  ○ Number of claims for emergency services
		  ○ Number of claims for in-network facilities using out-of-network providers

* Indicates pending federal legislation.

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No Surprises Act*	• Written and oral notice of the provider's network status is required at the time of scheduling. Written notice must include an estimated amount of charges and a list of any participating providers at the facility. • Requires consent from the beneficiary for out-of-network non-emergency care. • Providers/facilities must provide directory information to insurers they have contractual relationships with • Each health care provider and facility must make publicly available the prohibitions on balance billing, amounts that may be charged for items or services, and contact information for federal agencies if in violation of these requirements. • Emergency air ambulance providers must submit to insurers the cost of air travel and the cost of emergency medical services and supplies. <u>Penalties</u> • State has been given enforcement authority. But, if the state fails to enforce the requirements, the Secretary of HHS oversees enforcement and penalties. • The Secretary may apply a civil monetary penalty not to exceed $10,000 per violation. • Penalties can be waived if within 30 days of the issuance of the bill, the bill is withdrawn and reimbursed plus interest (as established by the Secretary). • Secretary may establish a hardship exception to the civil monetary penalties	• Must establish a provider directory database indicating network status. Must update the directory every 90 days. • Must make available on a public website information regarding prohibitions against balance billing and contact information for federal agencies if in violation. <u>Penalties</u> • State has been given enforcement authority, but if the state fails to enforce the requirements, the Secretary of HHS oversees enforcement and penalties. • The Secretary may apply a civil monetary penalty not to exceed $10,000 per violation.
Protecting Patients from Surprise Medical Bills Act*	• N/A	• Insurers must publish online a list of network providers and update it monthly. • Must provide annual notification to beneficiaries regarding the potential for balance billing when using an out-of-network provider.

* Indicates proposed federal legislation

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End Surprise Billing Act of 2019*	• Requirement of notice by the hospital/facility and consent by the beneficiary for care. • Notice must include the hospital's network status for both the hospital and providers and an estimated amount of charges for out-of-network care. • Condition for participation in Medicare; non-compliance could lead to loss of Medicare participation status.	• N/A
Lower Health Care Costs Act of 2019*[1]	• Requires notice and consent for beneficiaries admitted after emergency services. This applies for out-of-network facilities and in-network facilities using out-of-network providers. Must provide an estimated amount of charges, a list of in-network providers and facilities, and any prior authorization requirements. • Requires a good faith estimate of the expected cost-sharing for a health service (plus any services expected in conjunction) as soon as practicable and not later than two business days after the request is received. • Providers, at a minimum must submit their directory information to insurers when (1) provider begins network agreement, (2) provider terminates a network agreement, (3) there are material changes to the directory information, and (4) every 90 days. <u>Penalties</u> • Application of civil monetary penalties not to exceed $10,000 per violation. • Secretary may establish a safe harbor period when if the bill is withdrawn within 30 days the insurer or beneficiary is reimbursed plus interest.	• Removes gag clauses on price and quality information for the individual and group health plans. • Requires online and print provider directories. Must verify and update the online directory every 90 days and remove a provider if the insurer has been unable to verify network status. • Requires a good faith estimate of the expected cost-sharing for a health service (plus any services expected in conjunction) as soon as practicable and not later than 2 business days after the request is received. <u>Penalties</u> • If the directory information is incorrect and the beneficiary relies upon it, the beneficiary must not pay more than the in-network cost-sharing amount. If the beneficiary has already paid this amount, they must be reimbursed. • Civil monetary penalties may be applied that are not to exceed more than $10,000 per violation.

[1] Includes provisions for prescription drug transparency and the creation of a non-governmental, non-profit transparency organization with the goal of lowering health care costs.

* Indicates proposed federal legislation

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MARYLAND LAW		
Maryland statutes and regulations focus heavily on the need for transparency for out-of-pocket health care costs. Specifically, there is a focus on providing patients with written estimates, network transparency for insurer networks, and notification/consent prior to receiving out-of-network care.		
	Medical Providers/Facilities	**Insurance Companies**
Maryland Statutes and Regulations[2]	• Requires hospitals to provide an information sheet before scheduled services, before discharge, with the hospital bill, and upon request. The sheet must include information on the financial assistance policy, the patient's rights and responsibilities regarding billing, a statement that physician charges are usually billed separately, notice that hospitals can charge a facility fee, and the patient's right to request a written estimate of the charges. • Upon request, the hospital must provide a written estimate of the total charges for non-emergency care and services. • Requires non-preferred providers seeking assignment of benefits to provide notice to the patient that they might be charged at a higher rate and that they might be charged for services not covered by their insurance. Prior to performing the service, the patient should be provided with an estimated cost of the service, any payment terms, and if there will be interest charged.	• Must notify the enrollee if their primary care provider is terminated from the network and inform them of their right to continue seeing their primary care provider for 90 days following the issuance of network termination notice. • Must make network directory available online and upon request in a printed form.[3] • If directory information is reported as incorrect the carrier must investigate the claim and update the directory within 45 days of the notification. • Carriers must update their printed directory yearly. Must update their online directory at least once every 15 days. <u>Penalties</u> Maryland Insurance Administration can impose penalties for inaccurate network information. Prior to imposing a penalty, MIA can consider a variety of factors including attempts to achieve accurate network information from the provider or if the carrier includes the last time the information was updated from that particular provider in the directory.

[2] Generally, Maryland statutes govern insurance companies while HSCRC regulations government medical providers/facilities.
[3] HSCRC is also given the authority to establish a multicarrier-common online provider directory information system.
[*] Indicates proposed federal legislation