About CPR

An independent non-profit corporation working to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace.

15M+ covered lives, $80B+ annual health care spend

• 32BJ Health Fund
• Aircraft Gear Corporation
• Aon
• Arizona Health Care Cost Containment System (Medicaid)
• AT&T
• CalPERS
• Compassion International
• Covered California
• Equity Healthcare LLC
• General Motors
• Group Insurance Commission, MA
• Hilmar Cheese Company, Inc.
• The Home Depot
• Independent Colleges and Universities Benefits Association
• Mercer
• Miami University (Ohio)
• Ohio Department of Medicaid
• OhioPERS
• Pennsylvania Employees Benefit Trust Fund
• Pitney Bowes
• Qualcomm Incorporated
• San Francisco Health Service System
• Self-Insured
• Schools of California
• South Carolina Health & Human Services (Medicaid)
• Teacher Retirement System of Texas
• TennCare (Medicaid)
• Unite Here Health
• Walmart Inc.
• Washington State Health Care Authority
• Wells Fargo & Company
• Willis Towers Watson

September 9, 2021

www.catalyze.org
CPR Goals and Offerings

Effective Payment Reform
Effective Purchasers
Effective Marketplace

EDUCATION
Online courses, webinars, and virtual summits

TOOLS & SUPPORT
Plug-and-play tools and resources

COORDINATION
Collaboratives, membership, and aligned sourcing

RESEARCH
Scorecards, report cards, and white papers
Why do We Need Transparency into Health Care Prices?

**EMPLOYEES:** Consumers have the right to know, though they may not use the information. Some, though few, are motivated to use it to seek care from more efficient, higher-quality providers.

**PURCHASERS:** Purchasers face rising health care costs and need to make informed decisions about benefit designs, provider network designs and payment models. Plus, many have asked plan members to take on more financial responsibility.

**PROVIDERS:** Providers could make more informed referrals to minimize total cost of care.

**POLICYMAKERS:** Prices and quality are unrelated - we need to expose when price variation is unwarranted and due to an imbalance of market power and determine whether policy intervention is needed.
Purchasers such as CalPERS and Safeway wanted to implement reference-based pricing, but health plan tools didn’t meet members’ needs.

In 2012, CPR issued a call to action

In 2018, CPR surveyed health plans on their tools

100% of plans offered or support a cost calculator.

78% of physician choice tools had integrated cost calculators.

78% of plans reported that cost information provided to members considers member benefit design relative to co-pays, cost-sharing, and coverage exceptions.

A secret shopping exercise during summer 2018 revealed pervasiveness of missing data
Where Do Employers Turn to Fill the Void?

Independent vendors with transparency tools, navigation support, second opinion services, etc.*

But health plans restrict the data they will share with these vendors.

*CPR does not endorse vendors
At the state level, there has been progress, but most states still receive an “F” per our report cards on state price transparency laws.
California has led in some areas

2011-2013 California banned gag clauses in provider contracts

2017 CA implemented surprise billing protections, setting payments for out-of-network doctors at the greater of 125% of the Medicare rate or the insurer’s average contracted rate

2018 CA established the intent to create an *all payer claims database* - now called the “Health Care Payments Data Program” - by July 1, 2023.

2021 Settlement on antitrust case against Sutter finalized; *no longer allow to hide prices* or interfere with benefit or provider network designs.
Federal Action on Transparency - Hospitals

In November 2019, CMS issued its final rule: “Price Transparency Requirements for Hospitals to Make Standard Charges Public” which includes payer-specific negotiated charges...

But few are complying.

Low Compliance From Big Hospitals On CMS’s Hospital Price Transparency Rule

Morgan Henderson, Morgane C. Mouslim

March 16, 2021

CMS sent out warnings to hospitals failing at price transparency. Some still

Hospitals Fall Short Transparency Rule Compliance

Hospital dissatisfaction with the Price Transparency rule now includes failure to comply with the regulation's provisions.

Health Affairs Blog


Majority of hospitals not complying with price transparency rule: JAMA

Published June 15, 2021

Just 5.6% of hospitals are compliant with price transparency rule

Failing to follow through on price transparency requirements could alienate a large swath of a given health system's customer base.

Jeff Lagasse, Associate Editor
In November 2020, HHS, the Department of Labor, and the Treasury finalized the “Transparency in Coverage Rule” requiring health insurers and group health plans to create an online member-facing price comparison tool, and publicly post machine readable files including in-network negotiated rates, among other payment amounts.

Deadline for posting machine readable files is July 1, 2022.

Deadline for price comparison tool with the first 500 services is January 1, 2023 and January 1, 2024 for full compliance.

Good faith estimates and advanced EOBs must be provided to insured and uninsured by providers and facilities by January 1, 2022, though the federal government will not enforce compliance right away.
Federal Action on Transparency - Health Insurers

As of Dec 27, 2020, the Consolidated Appropriations Act (CAA) prohibits insurers from agreeing to gag clauses on prices or quality.

As of Jan 1, 2022 (section 116, division BB, CAA) provider directories must be up to date regarding network status; no balance billing allowed if participant is incorrectly told provider is in network, meaning cost sharing must be as it would have been in network.
Necessary Purchaser Action

- Combat the barriers health plans erect when it comes to sharing data with purchasers and/or other vendor partners.

- Shine the spotlight on providers that aren’t complying with federal laws.
  - Potential to educate plan participants on provider price variation for frequently sought-after services.

- Hold health plans accountable for their compliance with federal laws.
  - Ask for updates and workplans to ensure plans are working to become fully-compliant by required dates.

- Don’t forget about transparency on provider quality (and quality variation)!

September 9, 2021
What actions can SFHSS take today (and tomorrow)?
THANK YOU

Suzanne Delbanco, Ph.D.
Executive Director
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### The No Surprises Act (applies for plan years on or after January 1, 2022)

- No balance billing for out-of-network (OON) emergency care, certain services provided by OON provider at an in-network (IN) facility (e.g., anesthesiologist), and OON care provided at IN facility without patient’s informed consent.
- If plan covers IN air ambulance services, IN cost-sharing applies to deductible and out-of-pocket maximum; air ambulance providers cannot balance bill.
- Upon request, plans must send plan participants an advanced explanation of benefits (EOB) before scheduled care. There are specific timing and content requirements.
- Price comparison tool must factor in participant cost-sharing based on plan year, geography, and participating providers. Guidance must be available via phone.
- Provider directory information must be verified at least every 90 days. Plan must respond to phone inquiries within one business day.

### Key Provisions of Recent Federal Regulations

**The Consolidated Appropriations Act**

- Removal of provider gag clauses with plans that prohibit publishing of price or quality information for referring providers, plan sponsors, business associates, and individuals.
- Reporting and analysis on direct or indirect compensation by broker-consultants, Mental Health Parity and Addiction Equity Act, and drug prices.

### Key Provisions of Recent Federal Regulations

#### Transparency in Coverage Regulations

- Effective for Plan Years after January 1, 2022, plans must publicly post three machine-readable files and update them monthly:
  - Negotiated rates and fee schedules with IN providers
  - Historical allowed amounts for covered items and services by OON providers
  - Negotiated rates and historical net prices for drugs provided by IN providers
- Upon request from participant, plans must disclose cost-sharing estimates for covered services from a particular provider:
  - Applicable to a specific list of 500 items/services by January 1, 2023
  - Applicable to all items/services by January 1, 2024
  - Specific content and timing requirements for disclosure