Health Care Price Transparency in the House

HB 1005: Health and Insurance Matters (Shaibley)

Requires hospitals and ambulatory surgical outpatient centers to post certain health care services pricing information by billing code on the hospital's Internet web site and sets forth requirements.

- 100 Total:
  - 70 shoppable services, as determined by CMS; and
  - 30 most common services by hospital
- Although we believe that the policy goal of this provision will be accomplished by establishing an APCD, IHA was able to negotiate this down from a requirement that would have been overly burdensome and useless to the public;
- This change aligns with the CMS rule (in current litigation), that requires the 70 "shoppable services" to be posted;
- IHA's goal is for this provision to serve as a mechanism for price transparency until the APCD is established, which will be more meaningful.

Requires a good faith estimate to be provided to a patient:

- Upon request from patient;
- Only for "nonemergency health care services"; and
- No later than three business days after request.
  - Separate provisions in the bill require good faith estimates from practitioners and insurers.
  - If a health carrier provides coverage to the individual through a network plan, the health carrier shall inform the individual whether the provider facility in which the nonemergency health care service will be provided and the practitioners who will provide the nonemergency health care service are included in the health carrier's network plan.
- IHA worked with Rep. Schaibley and stakeholders to improve this section.
- Things such as definition of "price," definitions of "nonemergency health care services," converting 72 hours to three business days and requiring insurers to provide timely information to hospitals to comply were among those changes.
- We believe this section is now in a good place, to allow hospitals to provide useful information, without impeding the current initiatives of hospitals already providing estimates to patients.

Requires provider facilities and practitioners to post signs and to provide Internet web site notices about the availability of good faith estimates.

- IHA was able to narrow the definition of "waiting room" to prevent this requirement applying to just about every room in a hospital.

Requires health carriers to provide Internet website notices about the availability of good faith estimates of coverage for nonemergency health care services.

Prohibits health provider contracts from including provisions that prohibit the disclosure of health care service claims data (including PBMs) to employers providing the health coverage and makes a violation an unfair and deceptive act.

- Great step in direction of more transparency, allowing employers to have access to claims data across the health care continuum.

Requires the Department of Insurance to submit a request for information and a request for proposal concerning the establishment and implementation of an all payer claims data base and sets forth requirements.

- IHA legislative agenda item
- Will provide consumers, employers, policymakers and researchers with a single source of truth when it comes to claims data.

Requires IDOI to implement a centralized credentials verification organization and credentialing process that:

- Uses a common application, as determined by provider type;
- Issues a single credentialing decision applicable to all health carriers, except as determined by the department;
- Recredentials and revalidates provider information not less than once every three (3) years;
- Requires attestation of enrollment and credentialing information every six (6) months; and
- Is certificated or accredited by the National Committee for Quality Assurance or its successor organization.

Surprise Billing in the House and Senate

The Indiana House and Senate are considering bills to address surprise billing this session. Both bills (HB 1004 and SB 3) would take the patient out of the middle and prohibit balance billing when a patient seeks care at an in-network facility but is treated by an out-of-network provider. The House and Senate are still working on compromise language to address the process for payment in these scenarios and have two different versions of this legislation that are moving through the process. Below is a breakdown of both bills. IHA continues to support a solution to surprise billing that would most importantly take patients out of the middle but also protect physician payment to allow doctors to be properly reimbursed for the high-quality care they provide. These bills will likely see further changes in the coming weeks.

House Version: HB 1004 (Smaltz)

The bill provides the following:

When a patient seeks care at an in-network facility, neither the facility nor the practitioner who provides services in the facility may charge more than the in-network rate.

However, an in-network facility, an out-of-network practitioner who provides services in the in-network facility, or an in-network practitioner may charge more than the in-network rate if the following conditions are met:

1. At least five days before the health care services are scheduled to be provided, the covered individual is provided a statement that:
    a. Informs the covered individual that the facility or practitioner intends to charge more than allowed under the network plan; and
    b. Sets forth an estimate of the charge; and
2. The covered individual signs the statement, signifying the covered individual's consent to the charge.
    a. If the charge of a facility or practitioner provided to a covered individual exceeds the estimate provided, the facility or practitioner shall explain in writing why the charge exceeds the estimate.

This language takes the patient out of the middle, but it does not address the process for payment between out-of-network practitioners and insurance companies. Provisions 1 and 2 are optional; not required; however, it

still does not solve the issue. The House and Senate are still working on compromise language to address this. IHA continues to support a fair way to pay independent out-of-network docs, whether through arbitration or some other market-based rate so that negotiations between providers and insurers are fair and on a level playing field.

Senate Version: SB 3 (Charbonneau)

The Senate's package to address surprise billing applies only in the emergency setting and also requires hospitals to provide out of pocket estimates within 5 business days of a scheduled procedure if requested by a patient. Like the House version, the surprise billing section takes the patient out of the middle but does not address the process for payment between out-of-network practitioners and insurance companies. Provisions of the bill are included below.

Prohibits billing a patient who receives emergency services from an out-of-network provider at an in-network hospital, an ASC, or birthing center for amounts that exceed the cost paid by the patient's insurance plus any deductibles, copayments, and coinsurance amounts.

For scheduled procedures, the bill requires hospitals, ASCs, and birthing centers to provide, upon request from the patient, a good faith estimate to the patient for the cost of care at least five business days before a health care service or procedure is provided.

- The estimate must include whether the cost included in the estimate is an in-network rate or an out-of-network rate, and the cost of any:
  - Expected facility, professional, and imaging services; and
  - Drugs or medical devices associated with the service or procedure
- If the estimate includes costs for an out-of-network provider providing the service/procedure, the estimate may include a range for the cost of the service/procedure.
- Requires the patient to acknowledge in writing receipt of the estimate and indicate whether to proceed with the service or procedure.

IHA is working on a floor amendment to require insurance companies to respond back to hospitals within 2 business days in order for hospitals to provide patients with out-of-pocket estimates within five business days. The language we have requested is as follows:

A health plan shall respond not later than two (2) business days to a request by:
(1) A hospital;
(2) An ambulatory outpatient surgical center; or
(3) A birthing center
For the patient's share of the cost of services for purposes of the estimate described in section (b)

The House and Senate will continue working on these packages and ultimately reconcile the differences between the three proposals.