Texas Hospital Association

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Overview of Hospital Price Transparency Initiatives

As consumers are asked to bear a larger share of health costs, whether through high-deductible health plans or increased cost-sharing requirements, interest in transparency around the price of health care services also has increased.

Texas hospitals believe that consumers should be engaged in their own health care decisions and have access to the necessary information to make prudent decisions. However, as with many issues in health care, price transparency is complex and needs the engagement not only of hospitals and consumers but of physicians, health plans, employers and other health care providers and facilities.

There are a variety of health care cost transparency initiatives in Texas and nationally that aim to make fee/price information more accessible to consumers. This document provides a summary.

PricePoint From the Texas Hospital Association

- The Texas Hospital Association launched the Texas PricePoint website (www.txpricepoint.org/) in 2007 to meet a need in the state for consumer-friendly hospital charge information. PricePoint uses publicly available data submitted by hospitals to the Texas Department of State Health Services to provide, at THA's expense, basic demographic, quality and inpatient charge information on Texas hospitals and to encourage consumers to ask their insurance plan and/or hospital for additional information and resources. Most hospitals are required to report their inpatient and limited outpatient discharge information to the Texas Health Care Information Collection within TDSHS. THA collects and reports this data for many of its member hospitals. The information submitted to the state includes billed charges, diagnosis codes, and procedure codes. Unlike hospitals, because physicians and freestanding emergency centers are not required to submit data to THCIC, their data are not available on Texas PricePoint.

- Although some THCIC data are available free of charge to the public through the TDSHS website, hospital-specific data are not included, except for a fee. Texas PricePoint provides access to free hospital-specific data. Texas PricePoint is not state mandated; THA voluntarily administers the website to provide, as a consumer service, more robust inpatient data. THA pays approximately $6,000 annually to the state for the THCIC data and approximately $11,000 annually to maintain the website. The website has an average of 750 user sessions and more than 5,000 page views per month.

NATIONAL INITIATIVES:

The Affordable Care Act

- The Affordable Care Act requires every hospital to establish and make public a list of its standard charges for items and services provided on an annual basis. Contracted reimbursement rates with insurers are proprietary and not subject to disclosure.

- In addition, non-profit hospitals must have publicly available written financial assistance policies for uninsured patients and those unable to pay for health care, which include eligibility criteria, the basis for calculating charges and the method for applying for financial assistance.

Centers for Medicare & Medicaid Services

- CMS posts on its website average hospital specific charges per patient and average Medicare payments for the most common diagnosis-related groups and 28 procedures. Currently, the most recent available data are from 2015. The CMS data includes, among other things, inpatient and outpatient hospital-specific data.

Texas Law

- The *Health Insurance Reimbursement Rates Consumer Information Guide*, the result of Senate Bill 1731, 80th Legislature, requires the Texas Department of Insurance to collect data from health plans to determine their reimbursement rates for physicians and hospitals for specific medical services. It also requires TDI to combine all responses and present summary information based on the 11 Health and Human Services regions in Texas. Through its website, TDI reports the average billed, paid and contracted or allowed amounts for certain services, based on data provided by health insurers and HMOs in Texas.

- SB 1731 also requires health plans, providers and hospitals to provide cost estimates to individuals who are uninsured or who are seeking out-of-network care. Patients choosing elective, inpatient services or nonemergency outpatient surgery may request an estimate of charges and payments, due within 10 days. Extending the charge estimate to emergency care would violate state and federal law – EMTALA – that requires hospitals to provide emergency treatment and stabilization to anyone who needs it, regardless of ability to pay.

- House Bill 2256, 81st Legislature, allows enrollees in fully insured preferred provider benefit plans or state employee benefit plans to request mediation of out-of-network claims in excess of $1000 (subsequently reduced to $500) that are sent by facility-based physicians for care provided at in-network hospitals. HB 2256 also requires physicians and hospitals to inform patients how to file complaints and requires hospitals to provide, if requested by a patient, a list of all physicians with hospital privileges and the names of contact information for each facility-based physician and physician group. Hospitals also must provide written notice to patients that they may receive a bill for services from a facility-based physician for the amount unpaid by their health plan.

- During the 85th legislative session, THA supported SB 507 to expand the availability of mediation for out-of-network claims originally made available under HB 2256. Prior to SB 507 becoming law, mediation was limited to bills resulting from care provided by health care providers at a hospital. Under SB 507, if a patient receives a bill for an out-of-network service requiring the patient to pay more than $500 and the claim is for: out of network emergency care (facility's bill or provider's bill) or any health care, medical service or supply provided at an in-network facility by an out-of-network

physician, health care practitioner or other health care provider (the provider's bill), the patient may request mediation from TDI. In addition, each out-of-network bill or explanation of benefits statement must contain language explaining the availability of mediation.

- THA also supported HB 3276, 85th Legislature, which now requires all hospital-affiliated and non-hospital-affiliated freestanding emergency centers to do one of the following:
  - Post a notice stating that the facility is not in-network with any insurance plans.
  - Post a list of the insurance plans in which the facility participates.
  - If the facility is in-network with one or more insurers, provide a list of those insurance plans on its website and confirm a patient's eligibility in writing.

FAIR Health

- FAIR Health, the result of a 2009 settlement with 12 health insurers in New York, is an independent repository of claims data provided by procedure code or by episode of care. Charges and reimbursement rates are provided on both an in-network and out-of-network basis. FAIR Health also provides cost estimates. FAIR Health organizes claims by a geographic area ("geozip"), usually based on the first three numbers of a zip code. FAIR Health groups charges into percentiles, from lowest to highest. For example, if a provider's price is in the 80th percentile for a certain service, 80 percent of the fees billed by other providers for the same service were that amount or lower.