PEBA
SC Retirement Systems and State Health Plan

South Carolina Public Employee Benefit Authority
Serving those who serve South Carolina

Meeting Agenda

Meeting Agenda |Finance, Administration, Audit and Compliance Committee|
Health Care Policy Committee |Retirement Policy Committee| Board of Directors
Wednesday, March 3, 2021 | Via teleconference: 888 475 4499 Meeting ID 646 749 5163 ##

Finance, Administration, Audit and Compliance Committee |9:30 a.m.

I. Call to Order
II. Approval of Meeting Minutes October 1, 2020 and December 2, 2020
III. 2021 Internal Audit Plan
IV. Old Business/Director's Report
V. Adjournment

Health Care Policy Committee | 10:30 a.m.

I. Call to Order
II. Approval of Meeting Minutes December 2, 2020
III. Benchmark Review
IV. New Federal Policies Affecting Health Plans
    i. Medicare Rebate Rule
    ii. Surprise Billing Legislation
    iii. Plan Transparency Rule
    iv. Hospital Transparency Rule
V. Old Business/Director's Report
VI. Adjournment

LUNCH

Notice of public meeting
This notice is given to meet the requirements of the S.C. Freedom of Information Act and the Americans with Disabilities Act. Furthermore, this facility is accessible to individuals with disabilities, and special accommodations will be provided if requested in advance.

Retirement Policy Committee| 12:30 p.m.

I. Call to Order
II. Approval of Meeting Minutes December 2, 2020
III. Deferred Compensation Program Amendments
IV. Defined Contribution Quarterly Reports
    i. Deferred Compensation Program Investment Performance Report
    ii. State ORP Investment Performance Report
V. Deferred Compensation Program Plan Summary
VI. Old Business/Director's Report
VII. Adjournment

Board of Directors | 2:00 p.m.

I. Call to Order
II. Approval of Meeting December 2, 2020
III. COVID Update
IV. National Legislative Update
V. Committee Reports
    A. Finance, Administration, Audit and Compliance Committee
    B. Health Care Policy Committee
    C. Retirement Policy Committee
        i. Deferred Compensation Program Amendments
VI. Old Business
    A. Director's Report
    B. Roundtable Discussion
VII. Adjournment

PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
Health Care Policy Committee

Meeting Date: March 3, 2021

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1. Subject: State Health Plan Benchmarks

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2. Summary: Rob Tester will review the latest iteration of the State Health Plan's annual comparison with national and regional benchmarks.

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3. What is Committee asked to do? Receive as information

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4. Supporting Documents:

(a) Attached: 1. SHP Benchmarks
2. SHP Benchmarks Appendix

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State Health Plan benchmarks

Health Care Policy Committee

March 3, 2021

State Health Plan enrollment as of February 2021

Participants		
Subscribers		291,662
Actives	196,848	
Retirees	91,464	
Others	3,350	
Spouses		86,555
Children		138,345
Total covered lives		**516,562**

Total employer groups: 778

Active subscribers	
State agencies	34,864
Higher education	25,934
School districts	86,515
Local subdivisions	36,782
Other	12,753
Total employees	**196,848**

Retirees	
Medicare	73,099
Non-Medicare	18,365
Total retirees	**91,464**

Numbers represent enrollment in the State Health Plan, the MUSC Health Plan and TRICARE Supplement Plan.

State Health Plan versus national trends

Claims expenditure growth

	Public and private sector insurance plans[1]	State Health Plan[2]
2016	6.9%	0.2%
2017	6.5%	2.4%
2018	7.1%	3.2%
2019	6.7%	2.3%
2020	6.6%	3.6%[3]
5-year average (2016-2020)	6.8%	2.3%

- Target is to maintain net expenditure growth at least two points below benchmark.

[1]Includes active participants and retirees under the age of 65 in private and public sector insurance plans.
[2]Trend is defined as net expenditure per member (includes employee and dependents).
[3]Incurred in 12 months; paid in 12 months.

The benchmark is a blended number derived from annual health care cost trend surveys produced by national consulting firms including Aon, Buck, PriceWaterhouseCoopers, Segal, and Willis Towers Watson when available

State Health Plan contribution rate increases versus CPI growth for medical care

	State Health Plan total rate increase		Medical care CPI increase
2017	0.6%	**2015**	2.6%
2018	2.5%	**2016**	4.1%
2019	5.7%	**2017**	1.8%
2020	0	**2018**	2.0%
2021	0	**2019**	4.6%
5-year average (2017-2021)	1.8%	**5-year average (2015-2019)**	3.0%

- Target is to control annual contribution increase to no more than CPI for medical care plus 3 percent.
- Two-year lag in CPI data used for measure because of timing of the State Health Plan rate setting process.

2020 average monthly total premiums[1]

	Single	Family
State Health Plan	$500	$1,305
Large public and private sector employers[2]	$646	$1,860
Public and private sector in South[3]	$624	$1,738
Public employers	$668	$1,800
Private – manufacturing	$648	$1,888
Private – financial services	$671	$1,958

[1]Average monthly total premiums in PPO (Preferred Provider Organization) plans
[2]Large public and private sector employers: ≥ 200 employees in public and private sectors
[3]Public and private sector employers in South includes Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

2020 average annual deductible[1]

	Amount
State Health Plan	$490
Large public and private sector employers[2]	$960
All employers	$1,204

[1]Average annual deductible in PPO (Preferred Provider Organization) plans
[2]Large public and private sector employers: ≥ 200 employees in public and private sectors

2019 average annual gross plan cost per active employee[1]

	Amount[2]
State Health Plan	$11,091
Public employers	$13,895
Private – manufacturing	$14,030
Private – financial services	$13,673
All employers	$13,139
Employers – 500+	$13,580
Employers – 20k+	$13,222
South[3]	$12,045

[1]Average cost in PPO (Preferred Provider Organization) and POS (Point of Service) plans
[2]Average annual gross plan cost per employee (medical and pharmacy only for active employees and their dependents) = (Claims cost for employee and dependents + administrative costs + employee contributions)/number of active employees
[3]South includes Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

2021 composite monthly premiums[1]

	Employer	Employee	Total
State Health Plan	$574.18	$160.08	$734.26
South[2]	$772.06	$190.98	$963.04
United States	$947.91	$173.70	$1,121.61
State Health Plan percentage of regional average	74.4%	83.8%	76.2%
State Health Plan percentage of national average	60.6%	92.2%	65.5%

Survey uses most prevalent plan among state employee options for analysis.
[1]Composite monthly premiums: Weighted average of all PEBA health subscribers enrolled in each coverage level
[2]South includes Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

Disclaimer

This presentation does not constitute a comprehensive or binding representation regarding the employee benefits offered by the South Carolina Public Employee Benefit Authority (PEBA). The terms and conditions of the retirement and insurance benefit plans offered by PEBA are set out in the applicable statutes and plan documents and are subject to change. Please contact PEBA for the most current information. The language used in this presentation does not create any contractual rights or entitlements for any person.

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Appendix: State Health Plan benchmarks

Health Care Policy Committee

March 3, 2021

2019 average monthly contribution by employees

	Single	Family
State Health Plan	$98	$307
Large public and private sector employers[1]	$115	$467
Public and private sector employers in South[2]	$105	$530

[1]Large public and private sector employers: ≥ 200 employees in public and private sectors
[2]Public and private sector employers in South includes Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

2020 average percentage of contribution by employer

	EE contribution	Total premium	ER contribution
State Health Plan			
Single	$98	$500	80.5%
Family	$307	$1,305	76.5%
Large public and private sector employers[1]			
Single	$115	$646	82.2%
Family	$467	$1,860	74.9%
Public and private sector employers in South[2]			
Single	$105	$619	83.0%
Family	$530	$1,360	68.0%

[1]Large public and private sector employers: ≥ 200 employees in public and private sectors
[2]Public and private sector employers in South includes Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

2020 average Rx copayment

	Amount
State Health Plan	$9/$42/$70
Public and private sectors[1]	$11/$35/$62

[1]Public and private sectors includes small and large firms with Health Maintenance Organizations, Preferred Provider Organizations

2019 median individual in-network deductible amount[1]

	Amount
State Health Plan	$490
Public employers	$600
Private – manufacturing	$750
Private – financial services	$750
All employers[2]	$2,000
Employers – 500+	$750
Employers – 20k+	$750
Public and private sector employers in South[3]	$750

[1]Median deductible amount in PPO (Preferred Provider Organization) and POS (Point of Service) plans
[2]All Employers deductible is higher because it includes deductibles for employers with less than 500 employees
[3]Public and private employers in South includes Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

2019 median individual in-network coinsurance maximum amount[1]

	Amount
State Health Plan	$2,800
Public employers	$3,000
Private – manufacturing	$3,000
Private – financial services	$3,600
All employers[2]	$5,000
Employers – 500+	$3,400
Employers – 20k+	$3,500
Public and private sector employers in South[2]	$4,000

[1]Median coinsurance maximum amount in PPO (Preferred Provider Organization) and POS (Point of Service) plans
[2]Public and private employers in South includes Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

2019 median prescription drug retail 3-tier copayment amounts

	Amount
State Health Plan	$9/$42/$70
Public	$10/$30/$50
Private – manufacturing	$10/$30/$55
Private – financial services	$10/$30/$50
All employers	$10/$35/$60
Employers – 500+	$10/$30/$50
Employers – 20k+	$10/$35/$60
Public and private sector employers in South[1]	$10/$35/$60

[1]Public and private employers in South includes Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia

2021 SHP member benefits and contributions compared to other SHPs in the Southeast

	Lower	Higher
Deductible	7	6
Coinsurance max	10	3
Generic copay	10	3
Brand copay	7	6
Employer contribution	11	2
Employee contribution	9	4
Total contribution	12	1

Data from the 2021 *PEBA 50-State Survey of State Employee Health Plans*

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PUBLIC EMPLOYEE BENEFIT AUTHORITY AGENDA ITEM
Health Care Policy Committee

Meeting Date: March 3, 2021

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1. Subject: New Federal Policies Affecting Health Plans

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2. Summary: There are a number of proposed or enacted federal policies that will affect health plans, including the State Health Plan, in varying degrees. Presenters from PEBA contractors Express Scripts (Medicare Rebate Rule) and Blue Cross of SC (Surprise Billing Legislation, Hospital Transparency Rule, Plan Transparency Rule) will describe each of these items and discuss their respective prospects, timing, and potential impact.

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3. What is Committee asked to do? Receive as information

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4. Supporting Documents:

(a) Attached: 1. Rebate Safe Harbor Rule (POS) Rebates
2. New Surprise Billing and Transparency Rules

MEDICARE D

Rebate Safe Harbor Rule: (POS) Rebates

Laura Crawn & Gary Kline

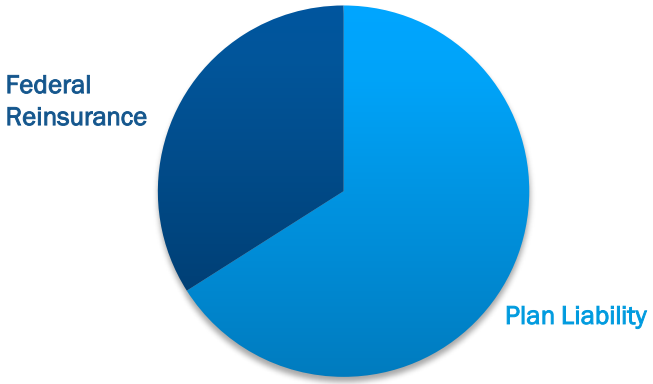
03/03/2021

BACKGROUND

What is a rebate & why are they important in Part D?

A ‘Rebate’ is a price concession paid by a pharmaceutical manufacturer to the health plan sponsor or the PBM working on the plans behalf. Rebates typically influence formulary tier placement or other utilization management criteria.

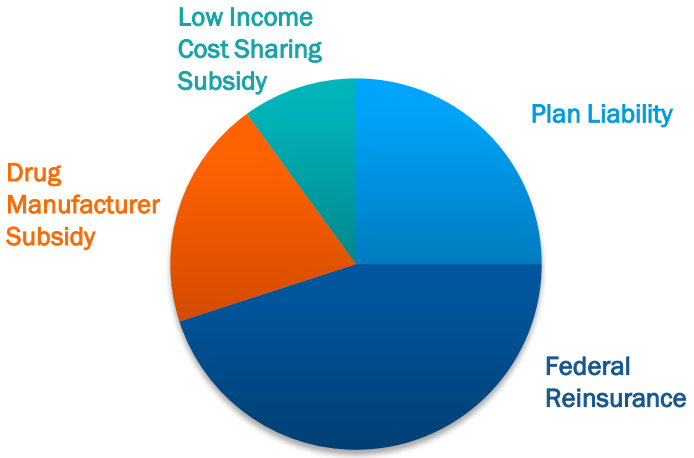
$1 REBATE TODAY



Currently in Medicare Part D:

- Rebates are shared with the government to reduce reinsurance
- Paid retrospectively

$1 POS REBATE*



If rebates are administered at POS:

- All stakeholders involved in paying claims receive a portion of the discount
- Must be paid at point of sale

REBATES AFTER THE POS ARE MORE VALUABLE FOR REDUCING NET PLAN LIABILITY.

* Depiction is reflective of a flat copay benefit

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Timeline

Final Rule

- Eliminates **safe harbor for drug manufacturer rebates** paid to PBMs – effective 1/1/2022
- Introduces two new safe harbors to protect **POS rebates and protects fair market value service fees** paid to PBMs by manufacturers – effective 1/29/2021

11/30/2020

Court Order

- **Delays elimination** of drug manufacturer rebates to PBMs/plans while HHS OIG reviews rule – **effective date delayed to 1/1/2023**
- Does not impact provisions scheduled to take effect prior to 2022

1/30/2021

Regulatory Freeze

- Places a temporary delay on the final rule (60 days) – effective 3/22/2021
- Delays until 3/22/2021 new Safe Harbors for POS rebates and fair market value service fees

1/29/2021

Status Update to Court

- Joint **status report** no later than **4/1/2021**

4/1/2021

Our path to 2023

Formulary

- POS rebate formulary under development
- Evaluation of generics and data-driven approach for brand inclusion to ensure lowest net cost

Advocacy

- Ongoing partnership with Pharmaceutical Care Management Association (PCMA) and America's Health Insurance Plans (AHIP)
- PCMA filed lawsuit to withdraw rule – resulting court order partially delays effective date and stays litigation while HHS OIG reviews rule. Shared goal is for the rule to be withdrawn

Point-of-Sale Implications

- Conducting full impact assessment of downstream processes, systems, and contracts
- Industry dependencies on NCPDP requirements being released
- NCPDP requirements pended due to delay and in absence of guidance from CMS

Rebates

- Work to maintain rebate value
- Apply rebates as point-of-sale discounts
- Assess implication on contract guarantees

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New Surprise Billing and Transparency Rules

Joel Pierstorff

PEBA℠
SC Retirement Systems and State Health Plan

AGENDA

CAA - Surprise Billing Provision

Transparency in Coverage Final Rule

Hospital Price Transparency Final Rule

South Carolina

CAA and the Surprise Billing Provision

- The Consolidated Appropriations Act (CAA) was enacted on December 27, 2020.
- One major provision of the CAA impacting group health plans and issuers of group and individual coverage (to include grandfathered plans) includes:
  - Elimination of Surprise Billing – effective January 1, 2022

Surprise Billing Provisions – Key Components

Five Components
Coverage Requirements
Qualifying Payment Amounts
Arbitration
Balance Billing
Air Ambulance Reporting

Surprise Billing – Coverage Requirements

<u>Requires plans to cover:</u>

- Services administered in an **emergency department** or **emergency services administered in a free-standing emergency department** without prior authorization, without respect to the providers' network status and applying in-network cost-sharing, *if the plan or issuer covers any benefits with respect to emergency services from an emergency department*. Emergency services include:
  - Ancillary services routinely available to evaluate emergency medical conditions
  - Items or services furnished after the patient is stabilized or as part of outpatient or inpatient services following the emergency admittance, *for which benefits are provided by the plan or issuer*
- **Non-emergency services performed by an out-of-network provider at an in-network facility** (except if the notice and consent requirements are fulfilled) and applying in-network cost-sharing
- **Out-of-network air ambulance services** for any services that would have been covered if the air ambulance provider was in-network and applying in-network cost-sharing

Surprise Billing – Coverage Requirements

- **In-network cost-sharing** to be calculated using payment amounts that would have applied to an in-network provider based on a "recognized amount" and to count towards the member's in-network deductible.
- **Recognized amount** is defined as:
  - The amount specified under any applicable state law or through an All-Payer Model Agreement
  - The qualifying payment amount for the applicable year in the absence of a state law or All-Payer Model Agreement
- Plans must **submit a direct payment** to the provider or facility or a notice of denial **within 30 days** after the bill is transmitted to the plan for all applicable items and services.

Surprise Billing – Qualifying Payment Amounts

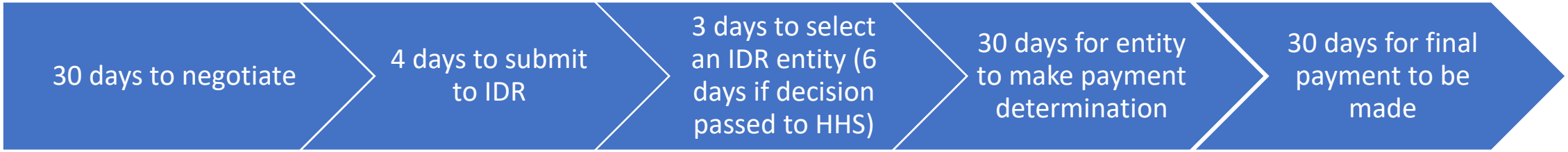
- Applies to most cost-sharing calculations for emergency and non-emergency services from non-participating providers and as a factor for the arbiter to consider in the independent dispute resolution (IDR) process
- Defined as the **median of contracted rates for a plan within a given market as of Jan. 31, 2019**, for the same or similar service provided by a provider within the same or similar specialty within a specific geographic region
  - Includes member cost-sharing
  - Must take into account non-fee-for-service payment types
  - Defines markets as individual, small group, large group and self-insured
- The qualifying payment amount increases year over year using the consumer price index for all urban consumers (CPI-U).

Surprise Billing – Qualifying Payment Amounts

- **New plans and coverage that start after 2019** must rely on their first year of data and apply CPI-U to year-over-year amounts for subsequent years.
- **For new items and services available after 2022** or for **instances where the plan does not have sufficient data**, plans may leverage any database determined by HHS not to have conflicts of interest and to have sufficient data on allowed amounts.
  - *Any fees associated with accessing a database are the responsibility of the plan.*

Surprise Billing - Arbitration

Arbitration process timeline:



Permits plans and providers to continue negotiations up until the IDR entity (arbiter) makes a final decision

Under the IDR process, the arbiter will **select either the plan's or provider's offer (baseball style):**

- The party whose offer is not chosen will be responsible for the costs of arbitration
- If a settlement is reached before the IDR determination is made, the two parties to split the costs
- The IDR determination is not binding if fraud is identified or if information is misrepresented to the IDR entity

Prohibits the party that submits an item or service for IDR to submit the same item or service for 90 days if it involves the same opposing party (i.e., the same plan and the same provider)

Surprise Billing - Arbitration

- **Arbiters must:**
  - Have sufficient expertise and staffing to make decisions on a timely basis
  - Not be affiliated with a health plan, provider group, facility or associated trade association
  - Appropriately carry out responsibilities and act with integrity, including maintaining confidentiality
- Any party can **petition to have an arbiter denied or removed** from the IDR process if not meeting the requirements.
- **Items and services can be batched** for submission, provided they are:
  - Furnished by the same provider or facility
  - Involve the same plan
  - Include items and services related to the treatment of a similar condition
  - The items and services were furnished within 30 days of each other
- Provides for **bundled payments to be considered a single determination**

Surprise Billing – Arbiter Considerations

Required

- Qualifying payment amount

Optional

- Level of training, experience, quality and outcomes measurement for provider or facility
- Market share held by provider and/or plan
- Case mix and scope of services of the facility
- Demonstrations of good faith efforts in network agreements on both side
- For air ambulance services, the ambulance vehicle type as well as the population density of the pick-up location

Not allowed

- Billed charges
- Medicaid/Medicare/Tricare/CHIP payment rates
- Usual and customary charges

Surprise Billing – Balance Billing

- Prohibits out-of-network facilities providing emergency services and out-of-network providers at in-network facilities from balance billing patients, with certain exceptions
- By Jan. 1, 2022, requires **providers and facilities to publicly post** and **provide to patients** information on:
  - The requirements and prohibitions in regards to balance billing
  - Information on applicable state laws related to what can be charged
  - State and federal agency contacts for filing complaints
- State agencies will be primarily responsible for oversight, but the **Tri-agencies will have authority to apply civil monetary penalties** to providers or facilities who do not comply with the balance billing requirements.

Surprise Billing – Balance Billing

Notice and consent:

- Permits out-of-network providers to continue to balance bill if they **give the patient written notice** at least 72 hours prior to receiving the services that includes the following **and the patient consents**:
  - Their network status
  - A list of in-network providers at the facility
  - Information about prior authorization or care management limitations
  - An estimate of charges
- It **cannot be used in instances where** the out-of-network provider is the only provider at the in-network facility who can perform the service (i.e., **the patient cannot chose someone in-network**) or when the result of unforeseen, urgent medical needs.
- **Providers furnishing ancillary services are excluded** and cannot balance billing patients with or without consent regardless of their specialty.
- **Defines ancillary services** as emergency medicine, anesthesiology, pathology, radiology, neonatology and other services defined by HHS as well as diagnostic services not included in a list to be defined and maintained by HHS.

Surprise Billing – Air Ambulance Reporting

- Air ambulance providers, as well as plans, must submit to the Tri-agencies a number of metrics on air ambulance services within 90 days of the end of a plan year.

Surprise Billing – Regulatory Action Timeline

- **Feb. 25, 2021**
  - Advisory Committee on Air Ambulance Quality and Patient Safety
- **July 1, 2021**
  - Qualifying payment amounts methodology
  - Notice and consent requirements
- **Oct. 1, 2021**
  - Qualifying payment amount audit process
- **Dec. 27, 2021**
  - IDR process, including certification of IDR entities and process for entity selection
  - Air ambulance reporting requirements
- **Jan. 1, 2022**
  - HHS begins qualifying payment audits
  - IDR public reporting begins
  - Process for receiving consumer complaints on providers

Transparency in Coverage FR – October 29, 2020

Final Rule requires most group health plans and issuers in the individual and small group markets to provide:

- **Personalized Disclosure of Out-of-Pocket (OOP) Costs (Initially effective Jan. 1, 2023):** Health plans must make available personalized OOP cost information, the underlying negotiated rates for all covered items and services, and out-of-network (OON) allowed amounts through a self-service tool and in paper form upon request.
- **Public Disclosure of In-Network (IN) Negotiated Rates (Effective Jan. 1, 2022):** Health plans must make publicly available three machine-readable files: 1) the IN negotiated rates with their providers; 2) the historical payments to OON providers and their billed charges; and 3) IN rates and historical net prices for covered prescription drugs.
- **Encouragement to Consumers to Shop for Services (Effective July 31, 2021):** Insurers can include provisions that encourage consumers to shop for services from lower-cost, higher-value providers.

Transparency Tools for Cost-Sharing Info

- **Initial tools required by Jan. 1, 2023**
- Upon request, plans (or contracted third-parties) must provide estimates of the following to members:
  - Cost-sharing liability
  - Accumulated amounts
  - IN rates in dollars (including negotiated rates and/or underlying fee schedule rates)
  - OON allowed amounts in dollars
  - For items and services that are part of a bundled payment, a list of all items and services included in the bundle
  - Notification if an item or service is subject to a prerequisite
  - A number of disclosures related to the estimate

Transparency Tools for Cost-Sharing Info

- These estimates must be available for **all types of items and services**, including: encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees (including facility fees) and:
  - By 2023, a subset of 500 specific items and services defined by HHS
  - By 2024, all items and services
- The tools must also provide the **ability to search by billing code and by descriptive term, the name of an IN provider or all IN providers and other factors** utilized by the plan or issuer for determining cost-sharing (e.g., location of service, facility name, dosage).
- The Rule also requires plans to have **the functionality to allow for users to sort by geographic proximity and amount of estimated OOP costs**, and requires estimates to be **available via website** as well as **paper upon request**.
- The Departments also include **good faith protections** if plans acts with reasonable diligence and address errors or omissions as soon as practicable, if an internet website is temporarily unavailable and the information is made available as soon as practicable, and if a plan obtains information from another entity and relies on that information in good faith.

Transparency – Machine-readable Files

- Effective Jan. 1, 2022
- The Final Rule requires health plans to make available to the public **three machine-readable files** of pricing information:
  1. **All applicable rates** (including negotiated rates, underlying fee schedules, or derived amounts) **with IN providers** for all covered items and services (the "in-network rate file")
  2. **Billed charges and allowed amounts** for covered items and services provided by out-of-network providers (the "allowed amount file")
  3. **Negotiated rates and historical net prices for prescription drugs** furnished by in-network providers (the "prescription drug file")
- This information must be posted on a **publicly accessible website, be free of charge, not require personal identifying information or an account** and be **updated on a monthly basis**.
- Plans can **contract with a third party** to provide this information, but will still be responsible for compliance.
- Similar **good faith protections** as included for the consumer tools apply for the machine-readable files.

Transparency – Machine-readable Files

- The files must include the following content elements:
  - **Name or identifier** (e.g., Employer Identification Number or Health Insurance Oversight System ID) for each plan option or coverage
  - **All billing codes** used by the plan to identify items or services for claims adjudication, accounting or billing, including: CPTs, HCPCS, DRGs, NDCs and other common codes (e.g., hospital revenue codes). These must be associated with each negotiated rate or allowed amount and include a plain language description.
  - **All applicable rates,** including negotiated rate, underlying fee schedule rates or derived amounts for individual items and services and items and service sin a bundled payment
  - The **date** of the last update
- **Negotiated rate**
  - Negotiated rates that change based upon participant, beneficiary or enrollee-specific characteristics must be provided with a calculated dollar amount for each provider prior to adjustment and be associated with the provider's National Provider Identifier (NPI), Tax Identification Number (TIN) and place of service code.
  - The last date of the contract term for each negotiated rate would also be required.
  - Indication with a notation where a reimbursement arrangement other a standard fee-for-service pricing model applies.

Transparency – Machine-readable Files

- Allowed amount
  - **Each unique allowed amount** in connection with covered items or services furnished by a specific OON provider within the 90-day period beginning 180 days prior to publication of the file.
  - If reimbursed based on a formula or reference-based price, plan would need to provide a **calculated dollar amount** for each item or service furnished by an OON provider.
  - Allowed amounts must be associated with the **provider's NPI, TIN and place of service code**.
  - To address privacy concerns, plans **would not be required to report payments when there are fewer than 20 different claims** for payment to a specific provider and only unique OON allowed amounts to mask the total episodes of care to a specific provider.
  - Allowed amount **can be aggregated across more than one plan or policy** and the **file can be hosted on a third-party website**. provided the plan links to the location on its own website
- Pharmacy rates
  - **Negotiated rates reflected as dollar amounts** and **associated with the provider's NPI, TIN and place of service code** as well as the last date of the contracted term
  - **Historical net prices** that are reflected as dollar amounts and associated with the NPI, TIN and place of service code for each IN provider as well as the 90-day period beginning 180 days prior to publication of the file for **NDCs with more than 20 separate claims**

Hospital Price Transparency Rules

CMS Finalize Rules November 15, 2019 – effective January 1, 2021

- Focused on increasing price transparency of hospital standard charges.
- Finalized definitions around “hospital”, “standard charges”, and “items and services”
- Requirements include:
  1. Making public all standard charges for all items and service in **machine-readable format**
  2. Displaying shoppable services in a **consumer-friendly manner**

South Carolina

Hospital Price Transparency Rules

Machine-readable Format Requirement

For each hospital location, hospitals must make public all their standard changes (including gross charges, payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices) for all items and services online in a single digital file in a machine-readable format.

Hospital Price Transparency Rules

Specifically, they must:

- Include a description of each item or service (including both individual items and services and service packages) and any code (for example, HCPCS codes) used by the hospital for purposes of accounting or billing.
- Display the file prominently and clearly identify the hospital location with which the standard charges information is associated on a publicly available website using a CMS-specified naming convention.
- Ensure the data is easily accessible, without barriers, including ensuring the data is accessible free of charge, does not require a user to establish an account or password or submit personal identifying information (PII), and is digitally searchable.
- Update the data at least annually and clearly indicate the date of the last update (either within the file or otherwise clearly associated with the file).

Hospital Price Transparency Rules

Requirements for Displaying Shoppable Services in a Consumer-Friendly Manner

- Hospitals must make public standard charges for at least 300 "shoppable services" (including 70 CMS-specified and 230 hospital-selected) the hospital provides in a consumer-friendly manner.
- "Shoppable service" is defined to mean a service that can be scheduled by a health care consumer in advance.
- Goal is to allow consumers to make apples-to-apples comparisons of payer-specific negotiated charges across healthcare settings.

Hospital Price Transparency Rules

Specifically, they must:

- Display payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices for at least 300 shoppable services, including 70 CMS-specified shoppable services and 230 hospital-selected shoppable services. If a hospital does not provide one or more of the 70 CMS-specified shoppable services, the hospital must select additional shoppable services such that the total number of shoppable services is at least 300. If a hospital does not provide 300 shoppable services, the hospital must list as many shoppable services as they provide.
- Include a plain-language description of each shoppable service, an indicator when one or more of the CMS-specified shoppable services are not offered by the hospital, and the location at which the shoppable service is provided, including whether the standard charges for the shoppable service applies at that location to the provision of that shoppable service in the inpatient setting, the outpatient department setting, or both.

Hospital Price Transparency Rules

Also, they must:

- Select such services based on the utilization or billing rate of the services. In other words, the shoppable services selected for display by the hospital should be commonly provided to the hospital's patient population.
- Include charges for services that the hospital customarily provides in conjunction with the primary service that is identified by a common billing code (e.g. Healthcare Common Procedure Coding System (HCPCS) codes).
- Make sure that the charge information is displayed prominently on a publicly available webpage, and clearly identifies the hospital location with which the standard charge information is associated.
- Ensure the data is easily accessible, without barriers, including ensuring the data is accessible free of charge, does not require a user to register, establish an account or password or submit PII, and is searchable by service description, billing code, and payer.
- Update the information at least annually and clearly indicate the date of the last update.

Hospital Price Transparency Rules

May be deemed compliant with the requirements around publicizing **300 shoppable services in a consumer-friendly manner** if an internet-based price estimator tool is maintained, and it:

- Provides estimates for as many of the 70 CMS-specified shoppable services that are provided by the hospital, and as many additional hospital-selected shoppable services as is necessary for a combined total of at least 300 shoppable services.
- Allows health care consumers to, at the time they use the tool, obtain an estimate of the amount they will be obligated to pay for the shoppable service by the hospital.
- Is prominently displayed on the hospital's website and accessible to the public without charge and without having to register or establish a user account or password.


Thank You