Research Protocol for Hospital Chargemaster Rates and Surprise Medical Billing

Prepared by the Policy Surveillance Program Staff

August 2020
RESEARCH PROTOCOL
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Hospital Chargemaster Rates and Surprise Medical Billing Laws

I. **Date of Protocol:** June 2020

II. **Scope:** Collect, code, and analyze state statutes and judicial decisions regulating hospital chargemaster rates and surprise medical billing. State law governs whether hospitals can issue patients surprise medical bills, what recourse patients have against these bills, and the transparency of hospital pricing schemes. State courts have also adjudicated on this issue, notably involving aspects of contract law. This cross-sectional dataset captures the legal basis of hospital chargemaster rates, surprise medical billing, and related court decisions as of August 2020 for 50 states and the District of Columbia.

III. **Primary Data Collection**

   a. **Project dates:** May 2020 – August 2020.

   b. **Dates covered in the dataset:** This is a cross-sectional dataset analyzing state hospital chargemaster and surprise medical billing laws as of August 2020.

      The effective date listed for each jurisdiction is the date of the most recent version of the law or regulation within that state. If more than one law or regulation is included in the legal text for a state, the effective date reflects the date of the most recently amended or enacted law or regulation within the legal text.

   c. **Data Collection Methods:** The research team (“Team”) consisted of three legal researchers (“Researchers”) and one supervisor (“Supervisor”). Westlaw Next and Lexis Advance were used to identify hospital chargemaster rates and surprise medical billing laws in effect as of August 2020.

   d. **Databases Used:** Research was conducted using Westlaw Next, Lexis Advance, and state-specific legislature websites.

      i. Secondary sources referenced included data provided by Homestead Smart Health Plans,
      ii. Full text versions of the laws collected were collected from each respective state legislature website.
e. Search Terms:

i. Keyword searches:
   a. “chargemaster”
   b. “surprise bill”
   c. “balance bill”
   d. “hospital price transparency”
   e. “most favored nation”
   f. “health insurance”
   g. “hold harmless”
   h. “unconscionability”
   i. “procedural unconscionability”
   j. “substantive unconscionability”
   k. “quantum meruit”
   l. “breach of contract”
   m. “unjust enrichment”
   n. “indefiniteness”
   o. “unreasonable hospital prices”
   p. “APCD”
   q. “all payer claims database”
   r. “consumer-facing price comparison tool”
   s. “most-favored nation”
   t. “preferred provider agreement”
   u. “consumer protection”

ii. Search strings:
   a. “hospital and publish and cost”
   b. “hospital and publish and price”
   c. “hospital and disclose and cost”
   d. “hospital and disclose and price”
   e. “hospital and transparency”
   f. “hospital and database”
   g. “hospital and website”
   h. “hospital and breach of contract”
   i. “hospital and quantum meruit”
   j. “hospital and unconscionable”
   k. “hospital and unreasonable and bill”
   l. “hospital and balance bill”
   m. “hospital and balance bill and arbitration”
   n. “hospital and lien”
   o. “consumer protection and hospital”

iii. Key word searches were supplemented by reviewing the table of contents chapters of hospital chargemaster rates and surprise medical billing laws.

iv. Once all the relevant statutes, regulations, and judicial decisions were identified for a jurisdiction, a Master Sheet was created for each jurisdiction. The Master Sheet for each jurisdiction includes the most recent statutory history for each statute and regulation. The most recent effective dates, or
the date when a version of law or regulation becomes enforceable, are recorded for each relevant statute and regulation.

v. All 51 jurisdictions were 100% independently, redundantly researched to confirm that all relevant law was collected by the Researchers.

vi. Divergences, or differences between the original research and redundant research, were reviewed by the Supervisor and resolved by the Team.

f. Initial Returns and Additional Inclusion or Exclusion Criteria: Included laws pertaining to state-level hospital chargemaster rates and surprise medical billing statutes and judicial decisions.

i. The following variables were included in the state hospital chargemaster rates and surprise medical billing laws dataset:
   - Hospital price transparency laws, including both publication to the public/state agencies and disclosure to individual patients
   - Surprises medical bill protection laws
   - Protections from balance billing
   - Hospital-insurance negotiation laws
   - Most-favored nation clauses
   - APCD laws, or their functional equivalent
   - Consumer-facing price comparison tools, or their functional equivalent
   - Consumer protection laws pertaining to hospitals
   - Judicial decisions involving aspects of contract law

ii. The following variables were excluded in the state hospital chargemaster rates and surprise medical billing dataset:
   - Outpatient facility transparency laws
   - Insurance carrier transparency laws

IV. Coding (To be filled in after coding training.)

a. Development of Coding Scheme: The Team conceptualized updated coding questions that would focus on hospital chargemaster rates and surprise medical billing, and then circulated them to subject matter experts. When the questions were finalized, the Team entered them into MonQcle, a web-based software-coding platform. The team then used the collected law built on MonQcle to answer the developed question set.

b. Coding methods: Researchers coded responses based on objective, measurable aspects of the law. Caution Notes were provided to explain any unique regulations and/or where the law was unclear.
Below is an explanation of the specific rules used when coding the questions in the hospital chargemaster rates and surprise medical billing laws dataset.

**Question: “Does the state require hospital price transparency?”**
- Coded “Yes” if the state has a statute that either requires hospitals the publish charge information to a state agency or their website or requires hospitals to disclose estimated costs for services prior to providing care.

**Question: “Does the state require the publishing of hospital charge information?”**
- Coded “Yes” if the state has a statute that requires hospitals to publish certain charge information to either a state agency, or to do so independently on their own website.

**Question: “What information must be published?”**
- Coded “Most common procedures” if the statute mandates that hospitals must publish the cost of an enumerated number of most common procedures.
- Coded “Expected costs of services” if the statute mandates that hospitals must publish expected costs of services, either based on chargemaster rates or insurance carrier payouts.
- Coded “Annual Total Charge summary” if the statute mandates that hospitals must publish their ATC.
- Coded “Average reimbursement rate” if the statute mandates that hospitals must publish the average charges actually reimbursed to the hospital.

**Question: “Where must the information be published?”**
- Coded “To specific state department” if the statute dictates that hospitals publish certain charge information to a specific state agency.
- Coded “Hospital website” if the statute dictates that hospitals publish certain charge information to their own website.
- Coded “Posting within the hospital” if the statute requires hospital to publish the information within the physical space of the hospital.

**Question: “Does the state require disclosure of certain expected charges?”**
- Coded “Yes” if the state has a statute that mandates that hospitals disclose expected costs of services to patients prior to providing care.

**Question: “To which patients does the statute mandate hospital pricing disclosures apply?”**
- Coded “Uninsured” if the statute explicitly stated that disclosures applied to uninsured patients.
- Coded “Privately insured” if the statute explicitly stated that disclosures applied to covered individuals/enrollees.
- Coded “Publicly insured” if the statute explicitly stated that disclosures applied to covered individuals/enrollees, especially Medicare recipients.
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- Coded “Self-funded” if the statute explicitly stated that disclosures applied to patients covered by self-funded health plans.
- Coded “All patients” if the statute referred to “patients” vaguely, without any differentiation between them.
- Coded “State law does not specify” if the statute makes no mention of patients whatsoever.

**Question:** “Must patients request access to this information?”
- Coded “Yes” if the statute explicitly stated that patients can only receive such disclosures “upon request”.

**Question:** “Does the state have a statute that prohibits surprise medical billing?”
- Coded “Yes” if the state has a statute which explicitly states a prohibition on surprise medical billing generally or balance billing.

**Question:** “Does the law prohibit balance billing?”
- Coded “Yes” if the state has a statute which explicitly states a prohibition on balance billing.

**Question:** “What kinds of balance billing protections does the statutes include?”
- Coded “Hold patients ‘harmless’ for balance bills” if the statute contained hold harmless language, either explicitly or through its effective equivalent.
- Coded “Hold insurance carriers responsible for balance bills” if the statute explicitly stated that insurance carriers were responsible for all sums in excess of typical cost-sharing requirements.
- Coded “Prohibits providers from balance billing patients” if the statute explicitly prohibited providers from billing patients in excess of typical cost-sharing requirements.

**Question:** “In what settings are balance billing protections applied?”
- Coded “Emergency care” if the statute specifically applied balance billing protections to patients who received emergency medical care.
- Coded “Out-of-network providers at in-network facilities” if the statute specifically applied balance billing protections to patients who received medical care from an out-of-network provider while at an in-network facility.
- Coded “Out-of-network care” if the statute specifically applied balance billing protections to patients who received out-of-network medical care under any circumstances.
- Coded “Urgent care” if the statute specifically applied balance billing protections to patients who received medical care from a designated urgent care facility.
- Coded “In-network care” if the statute extended balance billing protections to in-network medical care.
- Coded “State law does not specify” if the statute makes no mention of the settings in which balance billing protections are applied.
Question: “Do balance billing protections apply to self-funded plans?”
- Coded “Yes” if the statute either explicitly mentions applicability to self-funded plans, or if the balance billing statute provided a broad population protection.

Question: “Do balance billing protection apply to the uninsured?”
- Coded “Yes” if the statute either explicitly mentions applicability to uninsured patients, or if the balance billing statute provided a general population protection.

Question: “Do balance billing protections apply to patients who were informed they would receive out-of-network services?”
- Coded “Yes” if the statute either explicitly mentions applicability to patients who were informed that they would receive out-of-network services, or if the balance billing statute provided protections regardless of the particular context.

Question: “At what rate are insurance health plans required to compensate out-of-network providers?”
- Coded “Contracted in-network rate” if the statute limited compensation to in-network rates.
- Coded “Rate by federal insurance plans” if the statute limited compensation to the rates paid by either Medicare or Medicaid.
- Coded “the cost of services” if the statute limited compensation to the actual cost or value of the medical services.
- Coded “Previously negotiated rate” if the statute limited compensation to either rates based upon previous negotiations between the carrier and provider, or a standard rate determined by law.
- Coded “State does not require certain services to be compensated” if certain out-of-network services were not required to be reimbursed.
- Coded “Future negotiated rate” if the statute laid out groundwork for determining compensation rates, either through calculations or a basic framework for determination.
- Coded “The average local rate for the same services” if the statute used any variation of language limiting compensation to the average or median rates in the area.
- Coded “State law does not specify” if the statute makes no mention of the relevant compensation rate.

Question: “Does this rate apply to self-funded plans?”
- Coded “Yes” if the statute either explicitly mentions applicability to self-funded plans, or if the balance billing statute provided a compensation rate applicable to the general population.

Question: “What kind of payments are patients responsible for?”
• Coded “Standard co-payments” if the statute stated patient responsibility for co-payments, or if the statute limited patient responsibility to “standard cost-sharing requirements”.
• Coded “Standard deductibles” if the statute stated patient responsibility for deductibles, or if the statute limited patient responsibility to “standard cost-sharing requirements”.
• Coded “Stand coinsurance” if the statute stated patient responsibility for coinsurance.
• Coded “State law does not specify” if the statute makes no mention of patient payment responsibilities.

Question: “Does the law provide a dispute resolution procedure?”
• Coded “Yes” if the statute provided a dispute resolution process for determining the rates by which carriers should compensate providers.

Question: “What kind of dispute resolution procedures are included?”
• Coded “Arbitration” if the statute laid out an arbitration process for resolving disputes.
• Coded “Mediation” if the statute out a mediation process for resolving disputes.
• Coded “State payment standard” if the statute provided standard rates of compensation to be used when there are disputes.
• Coded “Out-of-network reimbursement calculation database” if the statute provided a calculation database which processed claims in order to determine the proper rate of compensation.
• Coded “State official discretionary decision” if the statute left the determination of compensation rates to a state official, such as the Insurance Commissioner or an official in the Department of Health.

Question: “Does the state require an All-Payer Claim Database?”
• Coded “Yes” if the state has a statute establishing an All-Payer Claim Database, or a database which is the effective equivalent and is recognized by the APCD Council.

Question: “Does the state maintain a consumer-facing price comparison tool?”
• Coded “Yes” if the state has a statute establishing a tool or database designed to enable consumers to compare chargemaster/claim rates at various hospitals or other healthcare facilities.

Question: Does the state prohibit most favored nations clauses or exclusive preferred provider agreements?
• Coded “Yes” if the statute has a statute prohibiting carriers and providers from entering into contracts containing most-favored nations clauses or exclusive preferred provider agreements.

Question: “Are hospitals allowed to pursue legal action against patients for payments?”
• Coded “Yes” if the state has a statute authorizing hospital use of liens, referrals to collection agencies, or other forms of legal action to collect outstanding debt owed by patients.

Question: “Which actions may hospitals use?”
• Coded “Liens” if the statute permitted hospitals to have liens against debts owed by patients.
• Coded “Referral to collection agencies” if the statute permitted hospitals to refer debt collection to an authorized collection agency.

Question: “Does the law include protections for uninsured patients?”
• Coded “Yes” if the state had statutes which protect uninsured patients from collection practices or which laid out discount/charity programs, which effectively limited the amount of debt collection which could be claimed by a hospital against uninsured patients.

Question: “What protections are given to uninsured patients?”
• Coded “Payment immunity” if the statute provided that uninsured patients were not liable for medical bills.
• Coded “Payment immunity if financial inability to pay is proven” if the statute established an income threshold at which uninsured patients were not liable for medical bills.
• Coded “Collections caps if financial inability to pay is proven” if the state established an income threshold at which collection amounts were limited against uninsured patients.
• Coded “State law does not specify” if the statute made no mention of the specific protections.

Question: “Does the state have a consumer protection statute that applies to hospitals?”
• Coded “Yes” if the state has a consumer protection statute which applied to hospitals particularly.

Question: “Does state law determine the ‘reasonable value’ of healthcare services?”
• Coded “Yes” if the state has a statute which explicitly states the method by which it determines the reasonable value of healthcare services.

Question: “How has state law determined the ‘reasonable value’ of healthcare services?”
• Coded “The listed chargemaster price” if the statute stated that the reasonable value of healthcare services was the price listed on each hospital’s chargemaster.
• Coded “The insurance carriers contracted price with other providers” if the statute stated that the reasonable value of healthcare services could be determined by providers and carriers through a comparison of contracted rates.
• Coded “The average local rate for the same services” if the statute stated that the reasonable value of healthcare services was determined by averaging the local rates of services.
• Coded “The rate paid by federal insurance plans” if the statute stated that the rates paid by Medicare of Medicaid determined the reasonable value of healthcare services.
• Coded “The cost of services” if the statute determined the reasonable value of healthcare services to be the actual cost or value of the services.
• Coded “Rates determined by a state official” if the statute left the determination of the reasonable value of healthcare services to the discretion of a state official, such as the Insurance Commissioner or an official in the Department of Health.
• Coded “Rates determined by expert opinion” if the statute left the determination of the reasonable value of healthcare services to the discretion of a relevant expert, such as a financial representative for the hospital or neutral research experts.

**Question:** “Have state courts determined the ‘reasonable value’ of healthcare services?”
• Coded “Yes” if state courts have ruled on the reasonable value of healthcare services, either by interpreting an existing statute with non-explicit language or by creating the method for determining reasonable value independent of legislation.

**Question:** “How have courts determined the ‘reasonable value’ of healthcare services?”
• Coded “The listed chargemaster price” if the court held that the reasonable value of healthcare services was the price listed on each hospital’s chargemaster.
• Coded “The insurance carriers contracted price with other providers” if the court held that the reasonable value of healthcare services could be determined by providers and carriers through a comparison of contracted rates.
• Coded “The average local rate for the same services” if the court held that the reasonable value of healthcare services was determined by averaging the local rates of services.
• Coded “The rate paid by federal insurance plans” if the court held that the rates paid by Medicare of Medicaid determined the reasonable value of healthcare services.
• Coded “The cost of services” if the statute determined the reasonable value of healthcare services to be the actual cost or value of the services.
• Coded “Rates determined by a state official” if the court left the determination of the reasonable value of healthcare services to the discretion of a state official, such as the Insurance Commissioner or an official in the Department of Health.
• Coded “Rates determined by expert opinion” if the court left the determination of the reasonable value of healthcare services to the
discretion of a relevant expert, such as a financial representative for the hospital or neutral research experts.

**Question:** “Have state courts banned balance billing?”
- Coded “Yes” if state courts have ruled against the enfor
cability of balance billing.

**Question:** “Did the court ban balance billing pursuant to theories of contract law?”
- Coded “Yes” if the court ruled against the enforceability of balance billing according to rationale consistent with principles of contract law.

**Question:** “What theories of contract law have courts recognized in invalidating balance bills?”
- Coded “Quantum Meruit” if the court ruled against balance bills pursuant to principles of Quantum Meruit.
- Coded “Breach of Contract” if the court held that balance billing breached the contract between a patient and provider.
- Coded “Unconscionability” if the court ruled against balance bills due to unconscionability, either due to open price terms, disparities in bargaining power, or other principles of unconscionability.

**Question:** “Have state courts found hospital-patient agreements (or their equivalents) to be unenforceable contracts due to their unconscionability?”
- Coded “Yes” if the court stated that hospital patient-agreements were unenforceable due to unconscionability.

**Question:** “Was procedural unconscionability found based, in part, on the unequal bargaining power between hospitals and their patients?”
- Coded “Yes” if the court explicitly stated that hospital-patient agreements were unenforceable due to procedural unconscionability.

**Question:** “Was substantive unconscionability found based, in part, on the unreasonableness of hospital pricing?”
- Coded “Yes” if the court explicitly stated that hospital-patient agreements were unenforceable due to substantive unconscionability.

V. Quality Control (Information below unchanged from template.)

a. **Quality Control – Background Research:** All 51 jurisdictions were 100% redundantly researched to confirm that all relevant laws were collected by the Researchers. The Researchers also consulted subject matter experts to verify whether state hospital chargemaster rates and surprise medical billing laws were within the scope of the dataset.

b. **Quality Control – Coding**
i. **Original coding:** Quality control of the original coding consisted of the Supervisor exporting the data into a Microsoft Excel document each day the Researchers completed coding to examine the data for any missing entries, citations, and caution notes.

ii. **Redundant coding:** The redundant coding process is 100% independent, redundant coding by two Researchers of each jurisdiction. Redundant coding means that each jurisdiction (a record) is assigned and coded independently by the two Researchers. Divergences, or differences between the original coding and redundant coding, are resolved through consultation and discussion with subject matter experts and the Team.

Quality control of the redundant coding consisted of the Supervisor exporting the data into a Microsoft Excel document each day the Researchers completed redundant coding to calculate divergence rates. 100% of the records were redundantly coded throughout the life of the project.

After coding the first 15 jurisdictions (Batch 1), the rate of divergence was 17% on July 13, 2020. A coding review meeting was held and all divergences were resolved. Several questions that were causing confusion were edited for clarity and then checked across the dataset to make sure coding was consistent. The Supervisor assigned the next 18 jurisdictions (Batch 2) for redundant coding and the rate of divergence was 19% on July 23, 2020. Divergences were again resolved through consultation and discussion with the Team. The Supervisor assigned the final 18 jurisdictions (Batch 3) for redundant coding and the rate of divergence was 11% on August 5, 2020. Divergences were again resolved, and the Team reviewed questions and answer choices for final clarity and relevance.

Once all jurisdictions were originally and redundantly coded, quality control was also conducted by comparing results to the three existing CPHLR datasets, and through consultation with a subject matter expert.

iii. **Post-production statistical quality control:** To ensure reliability of the data, a statistical quality control procedure (SQC) is run once all of the original and redundant coding is finished. To conduct SQC, the Supervisor takes a random sample of variables from the dataset for the Researchers to independently code. SQC occurs until divergences are below 5%. The Supervisor ran SQC after the dataset was completed on August 11, 2020. At that time, the divergence rate was 10%. Each divergence was then reviewed and resolved. The Supervisor then ran SQC again on September 3, 2020. At that time, the divergence rate was 4.6%. Each divergence was again reviewed and resolved, and the dataset was finalized.
iv. **Final Data Check:** Prior to publication, the Supervisor downloaded all coding data into Microsoft Excel to do a final review of coding answers, statutory and regulatory citations, and caution notes. All unnecessary caution notes were deleted and all necessary Caution Notes were edited for publication.