IMPLEMENTATION OF THE NO SURPRISES ACT CONSUMER NOTIFICATIONS STUDY

MAY 2024

As of May 2024 the final rule governing when and how an Advanced Explanation of Benefits to insured patients has not yet been issued by the federal agencies responsible for enforcing the No Surprises Act.

tnhealthcarecampaign.org

Office: 615-227-7500

TennCare and ACA Enrollment Hotline: 844-644-5443

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EXECUTIVE SUMMARY

The ***No Surprises Act of 2020*** (NSA) was a major milestone for U.S. health care consumers. The ***NSA*** restricts the practice of surprise balance billing by out-of-network providers in emergency situations and when insured patients seek nonemergency care at in-network facilities. The ***NSA*** requires insurers to keep online information on their provider networks up to date. The ***NSA*** also provides insured patients with the right to an Advanced Explanation of Benefits for scheduled procedures from their insurers, although, as of May 2024, the final rule on when and how this should be issued has not yet been released. Uninsured patients now have a similar right to a good faith estimate for the cost of care in advance of scheduled procedures. Importantly, the ***NSA*** creates a dispute resolution process that providers or insurers can pursue if no mutually agreeable payment amount can be negotiated between them, leaving insured consumers out of the process. It also created a patient-provider dispute resolution process for uninsured consumers if the actual charges are more than $400 above the good faith estimate.

In 2023, the Tennessee General Assembly requested that the Tennessee Department of Commerce and Insurance (TDCI) investigate how the federal dispute resolution process was being implemented in Tennessee and how providers and insurers were faring as a result. For consumers, the charge to the TDCI did not include a request to review how consumer-information requirements in the ***NSA*** were being implemented by insurers or providers.

The Tennessee Health Care Campaign (THCC), a statewide nonprofit consumer health advocacy organization, took part in a national survey being conducted by Families USA to assess whether hospitals were informing consumers of their new ***NSA*** rights. The survey also assessed whether hospitals were informing the public of hospital charges as required by the federal ***Price***

Transparency Rule. In addition, the survey looked at whether consumers had access to financial-assistance information on hospital websites.

THCC's survey included 105 Tennessee hospitals and took place between December 5, 2023, and January 5, 2024. THCC found:

- While 90% of Tennessee hospitals did have some information about the ***NSA*** posted on their websites, that information was often difficult to find. Only 57% of hospitals had the ***NSA*** information clearly linked to websites on billing or pricing, where most consumers would expect—and need—to find it.
- When consumers were informed about their ***NSA*** right to a good faith estimate of the cost of nonemergency procedures, only 65% of the time did that information include the right of uninsured patients to dispute a bill that was more than $400 over the estimate they were given.
- Hospital websites did not always inform consumers that they could contact TDCI if they had questions or complaints about coverage or billing issues. While we eventually found a mention of the TDCI on about 80% of the websites we reviewed, it was usually only as a footnote.
- There was more consistent compliance (91%) with posting information on the ***Hospital Price Transparency Rule of 2021,*** which requires hospitals to post a link to a downloadable charge sheet and a patient cost estimation tool on its homepage. While the downloadable charge sheet is not intended to be consumer-friendly, but to be used by health policy researchers and economists, the patient cost estimation tool is intended to make it easy for consumers to compare prices for care at different hospitals. These tools varied significantly in their ease of use, often requiring specific medical coding and detailed insurance policy information. Lengthy disclaimers indicated that some tools excluded certain costs from their estimates, making comparisons difficult.
- A majority, but not all hospitals (88%), provided information on their ***financial-assistance policies*** on their websites. Some hospitals made the information available in multiple languages and provided the option to download application forms also in multiple languages, while others offered only a brief statement that assistance was available and provided a number for further inquiries. The policies appeared to differ significantly in eligibility criteria as well. THCC hopes to conduct a more thorough review of the range of assistance available across the state in a subsequent survey.

The Tennessee Health Care Campaign recommends that Tennessee hospitals:

- **Standardize the location and quality of the information available to consumers about their balance billing protections; their right to a good faith estimate; their right to file complaints with state and federal agencies; their eligibility for financial assistance;**

their right to transparent pricing information. Further, hospitals must provide this information in multiple languages.

- **Ensure that potential patients have access to comparable cost-estimator tools by ensuring access through guest portals.**
- **Post detailed information about each hospital's financial-assistance policies' eligibility criteria and application processes in multiple languages and as downloadable forms.**
- **Expand the listings of Patient Rights and Responsibilities to include the new rights to be protected from balance billing and to price transparency.**
- **Provide TDCI with the resources to undertake a study to evaluate the consistency with which patients are receiving Advance Explanations of Benefits and good faith estimates in advance of their care and to support consumers through complaint procedures.**

INTRODUCTION TO TENNESSEE HEALTH CARE CAMPAIGN

The Tennessee Health Care Campaign (THCC) is a statewide, nonprofit, consumer-led organization founded in 1989 for the purpose of working toward a future where all Tennesseans have equitable access to comprehensive, quality, and affordable health care.

THCC was active in its first decade in advocating for TennCare I and continues to support efforts to broaden Medicaid eligibility levels for children, caregivers, and low-income adults across the state. In its second decade, the organization also began educating Tennesseans about the options for national health coverage then being debated in Congress. After the ***Patient Protection and Affordable Care Act (ACA)*** was eventually passed, THCC mobilized hundreds of volunteers across the state to help enroll uninsured Tennesseans in affordable plans on Healthcare.gov, or if eligible, in coverage through TennCare or Cover Kids. Today, THCC's enrollment work continues through a nonprofit insurance agency with licensed insurance agents to assist insured and uninsured Tennesseans gain access to the care they need.

In this decade, as part of our mission, THCC has also been monitoring efforts in the state legislature and in Congress to restrict the practice of balance billing patients (a.k.a. "surprise medical billing") for needed health care in emergency situations and when, in good faith, patients seek health care at a facility that is in their insurance provider's network. When Congress passed the bipartisan ***NSA,*** THCC worked to spread the word about the important consumer protections in the ***NSA.*** This survey is a continuation of this effort.

BACKGROUND ON THE NO SURPRISES ACT

The ***No Surprises Act of 2020*** resulted from a bipartisan effort in the U.S. Congress to control rampant growth in "surprise medical billing". Surprise medical bills were unexpected bills consumers received for services patients thought were covered by their health insurance policies. These "surprise" bills were generated by physicians who did not participate in insurance company networks, even though they might work in a facility which was listed as in-network by the insurer. This practice was particularly devastating in emergency situations where patients are transported of necessity to the nearest available emergency room without regard for insurance coverage or network affiliation.

Before the ***NSA*** was passed, when out-of-network care was covered by a patient's policy, insurance companies would pay providers an allowable amount determined by the insurer, and patients would pay their share of copayments to the providers as well. But too often, providers would also bill patients for the balance of the charges that the practice arbitrarily set for their

services. This was usually considerably more than, and often double or triple, the insurers' allowable amount. If patients could not pay this balance, they would be subject to debt collection practices that impacted their credit ratings and contributed to an epidemic of medical debt for hundreds of thousands of Americans.

The Sycamore Institute reported that in Tennessee, in 2016, 24% of Tennesseans had medical debt on their credit reports, the 10th highest rate among all fifty states [https://www.sycamoreinstitutetn.org/medical-debt-tennessee/]. It has been estimated by the Department of Health and Human Services that in the years leading up to the passage of the ***NSA,*** one in five Americans who went to an emergency room, had an elective surgery, or gave birth were receiving a surprise balance bill of between $750 and $2,600 per episode of care. [https://www.hhs.gov/about/news/2022/01/03/hhs-kicks-off-new-year-with-new-protections-from-surprise-medical-bills.html]. In the first few months of 2022, when the act became effective, the organization American Health Insurance Plans estimated that the ***NSA*** prevented 2,000,000 surprise medical bills alone! [More Than 2 Million Surprise Bills Avoided During January-February 2022" AHIP, May 2022]

The new patient rights created by the **NSA** for insured individuals include the following:

- **the right to be protected from balance billing for emergency medical services provided at any hospitals or freestanding emergency rooms**. Emergency services protected from balance billing now include post-stabilization services provided in hospital settings and air ambulance transport. [NOTE: due to variations in the way states and municipalities regulate ground ambulance services across the country, these are not yet covered by ***NSA.*** Recommendations on how to limit balance billing for emergency ground ambulance services are expected to be announced in early 2024.]
- **the right to updated information on the network status of providers on insurer's websites.**
- **the right to be protected from balance billing by any providers working at an in-network hospital, hospital out-patient department, or ambulatory surgical center** who are considered out of network, unless that right is specifically waived by the patient after being duly informed of their right to in-network provider care.
- **the right to an Advanced Explanation of Benefits (AEOB) from insurers indicating the expected cost of a scheduled procedure and the insured's cost-sharing obligation.** [Note: as of May 2024 the final rule on when and how the AEOB should be provided has not yet been released].

The new rights created for uninsured individuals include:

- **the right to a good faith estimate of the cost of nonemergency care** to be provided by the hospital to the patient at least three days prior to any scheduled procedures.

- **the right to dispute a bill that is more than $400 above the good faith estimate through an independent patient-provider dispute resolution process within 120 days of receiving the bill.**

These rights apply to consumers covered by employer-based health coverage, a federal or state ***ACA*** Marketplace plan, or a private individual health policy.

Under the ***NSA,*** once a patient pays their portion of their policy's in-network charges to out-of-network providers, they are left out of any ongoing disputes between the provider and the insurer over the amount of payment. The out-of-network rate that insurers pay providers outside their networks can be set to an amount a state approves under an All-Payer Model Agreement or another amount determined by state law. If no state law is in place, as is the case in Tennessee, the ***NSA*** encourages providers and insurers to negotiate a fair price. If negotiations are unsuccessful, the ***NSA*** also creates an independent arbitration process that either party can invoke to resolve their disputes. It is also important to note that while the ***NSA*** sets a floor for consumer protections, it allows states to enact stronger consumer protections, such as covering ground ambulance services.

During the time when the ***NSA*** was being debated in Congress, the Tennessee General Assembly had also been considering state regulation of balance billing. The proposed state legislation was similar to the ***NSA, but*** used a different criterion for determining what out-of-network providers would be paid. The state's dispute resolution process was considered by Tennessee provider organizations to be more favorable than the process set out in the ***NSA***. Indeed, Tennessee providers have been among the most prolific in the country in filing disputes over payment since the ***NSA*** was enacted. Multiple lawsuits by providers challenging the fairness of the dispute resolution process have complicated the ***NSA's*** implementation.

Due in part to these legal controversies and concerns, legislation enacted by the Tennessee General Assembly in 2023 directed the TDCI to *"conduct a study on the implementation of the federal **No Surprises Act** and its implications for physicians and healthcare facilities in this State."* TDCI issued that report in October 2023, entitled *Implementation of the Federal **No Surprises Act** Study pursuant to PC 352 of the 113th General Assembly.* That report focused primarily on the impact of the dispute resolution process and concluded:

> **"Based on the information collected and reviewed for this study, implementation of the NSA in Tennessee and across the nation has yielded mixed results. The Department finds that insured patients are protected from balance bills. However, the Department also finds dissatisfaction from the provider community and that the federal apparatus for resolving disputes regarding fair reimbursement between providers and insurers is overwhelmed.**

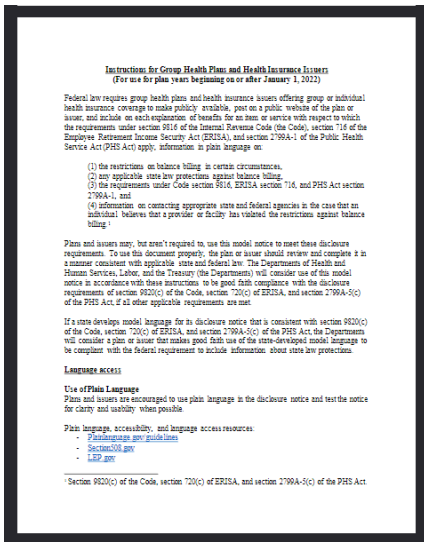
> **Due to the Department's finding that insured patients are protected, and due to the repeated legal challenges and instability from independent dispute resolution entities at both the state and federal level, *the Department does not recommend establishing a state-specific dispute resolution process at this time.*"** *[emphasis added in italics]*

As part of the preparation for this report, TDCI consulted with THCC about consumer concerns. THCC requested that, as part of the implementation report, TDCI survey Tennessee hospitals to ascertain if the consumer information required by the ***NSA*** was being properly posted on hospital websites across our state.

THCC also requested that TDCI seek evidence that patients were able to obtain information about their providers' network status and insurer-or facility-provided cost estimates in a timely manner as required by the ***NSA.***

While the TDCI report acknowledged our concerns, it did not include any information on whether hospitals were complying with the ***NSA*** consumer information provisions. Because we felt this was important to Tennessee consumers, THCC participated in a survey being conducted by the national health consumer policy organization FamiliesUSA to determine if the consumer information requirements of the NSA were being met.

This report summarizes our findings, and a list of recommendations to make information about the ***No Surprises Act*** more accessible and usable to Tennessee consumers follows.



Instructions for Group Health Plans and Health Insurance Issuers
(For use for plan years beginning on or after January 1, 2022)

Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

(1) the restrictions on balance billing in certain circumstances,
(2) any applicable state law protections against balance billing,
(3) the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
(4) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.[1]

Plans and issuers may, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the plan or issuer should review and complete it in a manner consistent with applicable state and federal law. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) will consider use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met.

If a state develops model language for its disclosure notice that is consistent with section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, the Departments will consider a plan or issuer that makes good faith use of the state-developed model language to be compliant with the federal requirement to include information about state law protections.

Language access

Use of Plain Language
Plans and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.

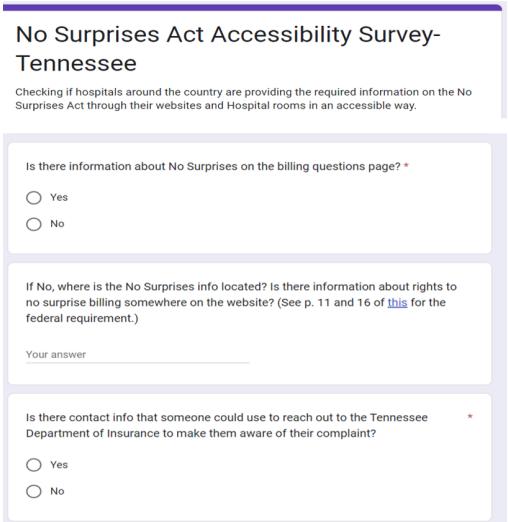
Plain language, accessibility, and language access resources:
- Plainlanguage.gov/guidelines
- Section508.gov
- LEP.gov

[1] Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act.

See the Centers for Medicare and Medicaid model ***NSA*** disclosure notice: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf

OUR SURVEY TOOL: The survey tool we used was created by Families USA as a Google form to collect information about whether hospital websites were clearly posting information about new consumer protections of the ***NSA***. The survey looked specifically at whether and where the information was posted, if it included a clear description of the prohibitions on balance billing, the right to a good faith estimate of the cost of nonemergency care, and the right of uninsured patients to dispute a bill if it exceeded the good faith estimate by more than $400. We also looked at whether hospitals were implementing the ***Price Transparency Act*** requirements to post a display of shoppable services in a consumer-friendly format that would allow consumers to compare potential costs of care at area hospitals. Additionally, we looked at whether information about the **financial assistance policies** of the hospitals were readily available to potential patients.

OUR SAMPLE: A list of Tennessee hospitals was obtained from the Tennessee Hospital Association website. A total of 105 hospitals were sampled. When hospitals were affiliated with larger health systems, we sampled at least two hospitals in each health care system to validate that their websites directed consumers to the same systemwide website for information on the ***No Surprises Act,*** Price Transparency tools, and financial assistance policies. The findings on the health system's website were then assigned to each other hospital in that system. We found that 82% of the 105 hospitals we sampled were now affiliated with one of fourteen health systems. Children's hospitals and specialty hospitals (e.g. women's hospitals or rehabilitation hospitals) were not included in the sample.



No Surprises Act Accessibility Survey-Tennessee

Checking if hospitals around the country are providing the required information on the No Surprises Act through their websites and Hospital rooms in an accessible way.

Is there information about No Surprises on the billing questions page? *

- Yes
- No

If No, where is the No Surprises info located? Is there information about rights to no surprise billing somewhere on the website? (See p. 11 and 16 of this for the federal requirement.)

Your answer

Is there contact info that someone could use to reach out to the Tennessee Department of Insurance to make them aware of their complaint? *

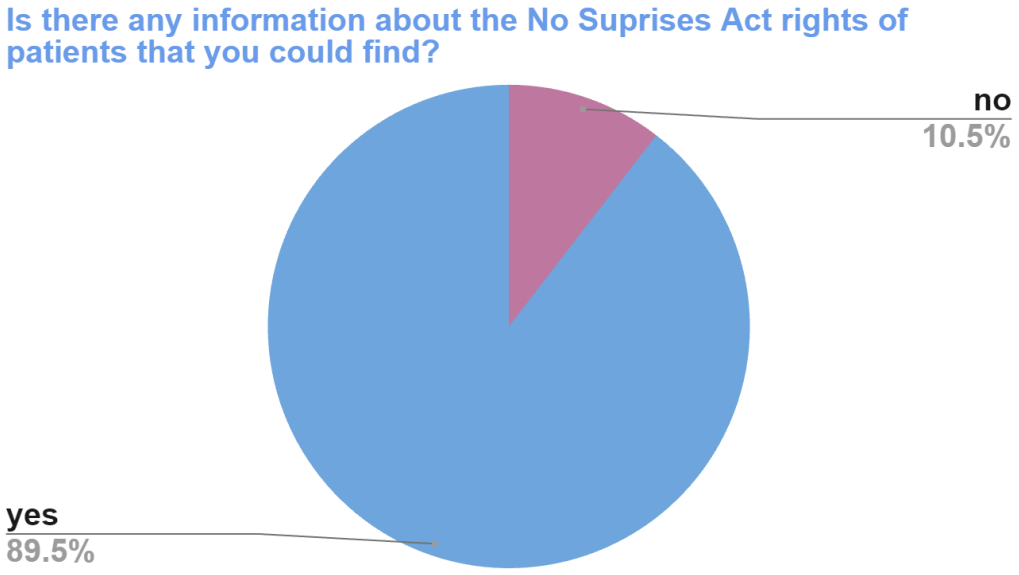
- Yes
- No

SURVEY RESULTS

Below are a series of graphs representing the answers to each of the questions in our survey of hospital websites, and a brief discussion of the findings.

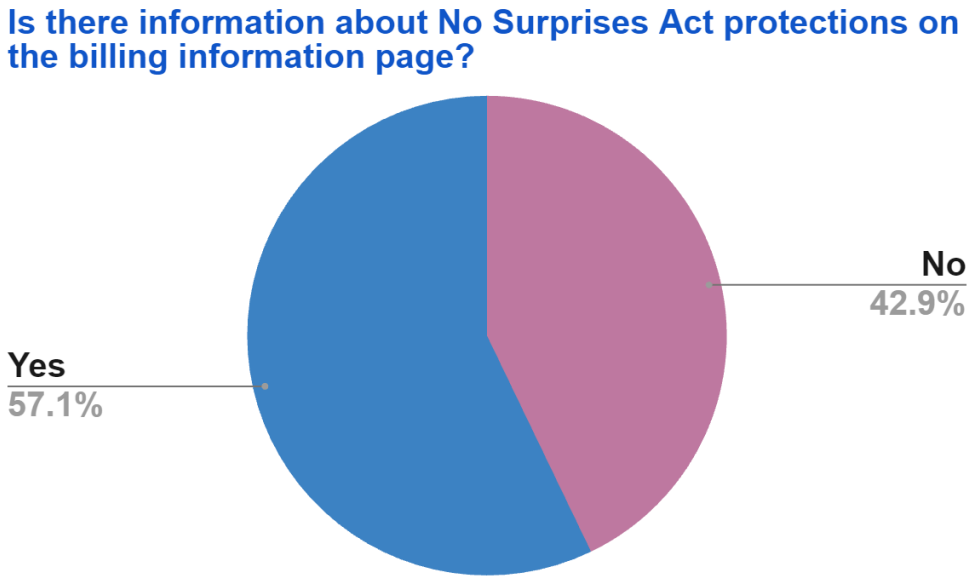
NO SURPRISES ACT

The first questions on the survey had to do with the ***NSA.*** In most cases, THCC volunteers were able to find some information on the ***NSA*** somewhere on the hospital websites.



NOTE: A NO was assigned only after the volunteer clicked on all available links to billing information, financial assistance information, price transparency information, or patient information links, and after typing "NO SURPRISES ACT" or "BALANCE BILLING" in a site search box yielded no results.

Since most consumers would look for information about balance billing policies on the billing information pages, the survey also asked if that is where the information could be found. Only 57% of websites sampled described the prohibitions against balance billing on links associated with "bill payment," "price transparency" or "financial assistance," where patients would most expect to find that information.



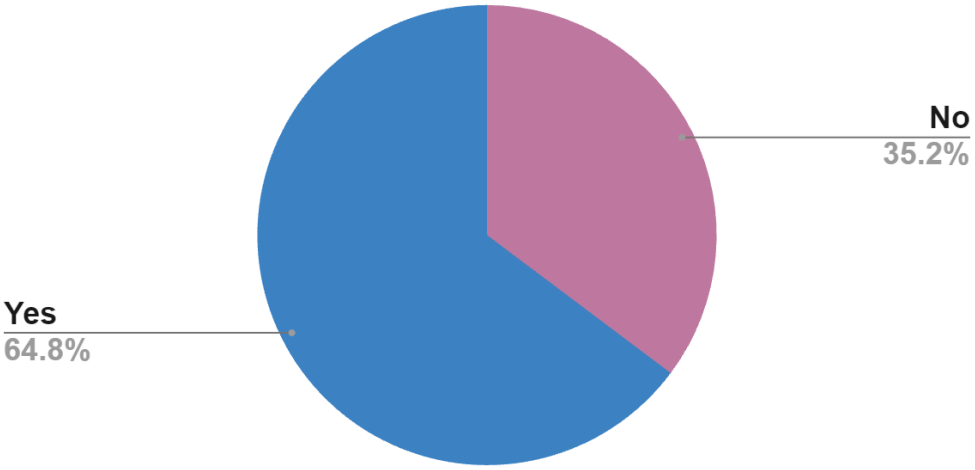
In addition to prohibiting balance billing for insured patients, the ***NSA*** guarantees *uninsured* patients two important new rights:

(1) the right to good faith estimate of what the cost of their care will be that is provided at least three days before a scheduled procedure, and

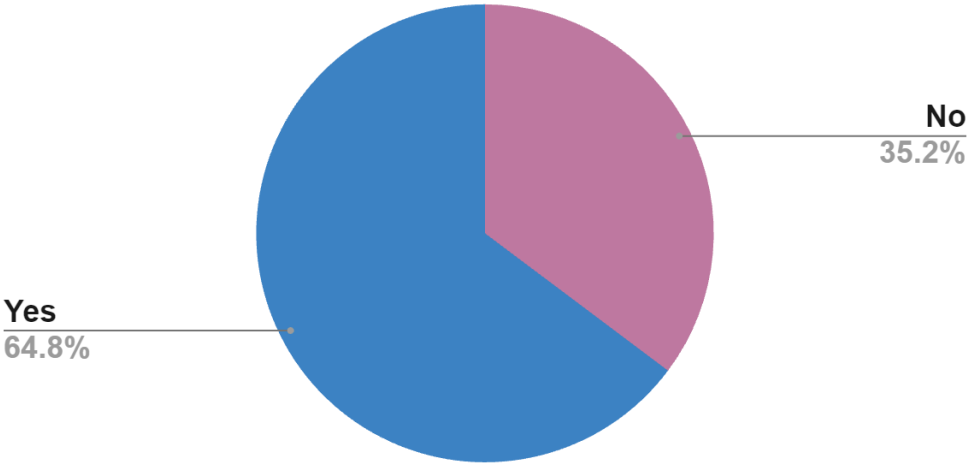
(2) the right to dispute the final charges for that care if that amount is more than $400 or the good faith estimate.

Our volunteers also queried whether this information was available on hospital websites. We found that this information was posted with less frequency than the ***NSA*** information for insured patients about balance billing restrictions. As the charts on the next page illustrate, *uninsured patients seeking care at one-third of Tennessee hospitals would not know about these rights from their current websites*!

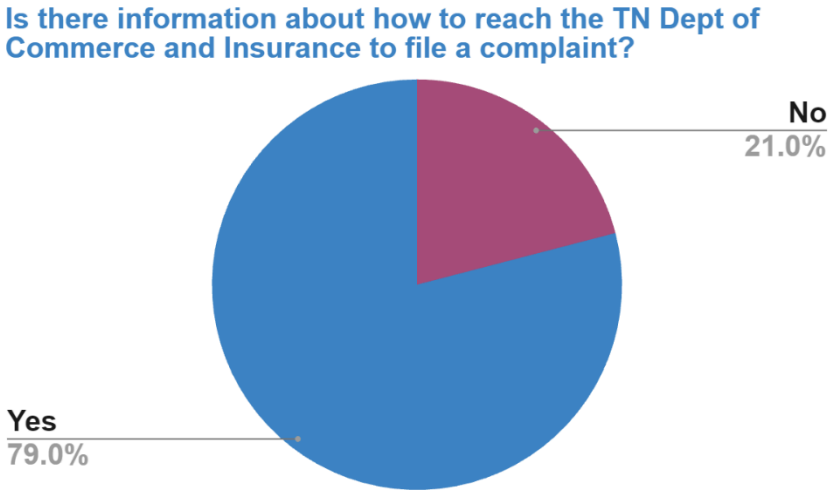
Is there posted information showing the right of uninsured persons to request resolution of a disputed bill if charges were more than $400 of good faith estimate?



Is there posted information showing the right of uninsured persons to request resolution of a disputed bill if charges were more than $400 of good faith estimate?



Volunteers also looked at whether a patient could find information on how to file a complaint if they were not fully informed of their rights and costs in a timely way, or if they received an improper bill. When information about filing complaints was posted, it was often found only if consumers followed a link to the CMS model disclosure agreement and read through to the bottom of the two-page document. The disclosure agreement also provided information on how to contact TDCI in most cases, but not all. The NSA is being jointly enforced through a collaborative agreement with the Centers for Medicare and Medicaid (CMS) and TDCI. TDCI will have jurisdiction over insurer responsibilities, and CMS will have jurisdiction over provider and consumer responsibilities. THCC feels it is important that consumers know when and how to contact both agencies, and that information on filing complaints should be much easier to find.



CMS consumer help resources: https://www.cms.gov/medical-bill-rights/help

Get Help

Call the No Surprises Help Desk

Get answers about your medical billing situation and see if the No Surprises Act applies. Or call to submit a complaint.

We're available 7 days a week: weekdays from 8:00 am - 8:00 pm Eastern Time (ET), and weekends from 10:00 am – 6:00 pm ET.

We can help you in Spanish, French, Arabic, Russian, Nepali, and over 350 other languages. Call us for resources in accessible formats like large print, Braille, and audio.

Call our Help Desk at 1-800-985-3059.

PRICE TRANSPARENCY RULE

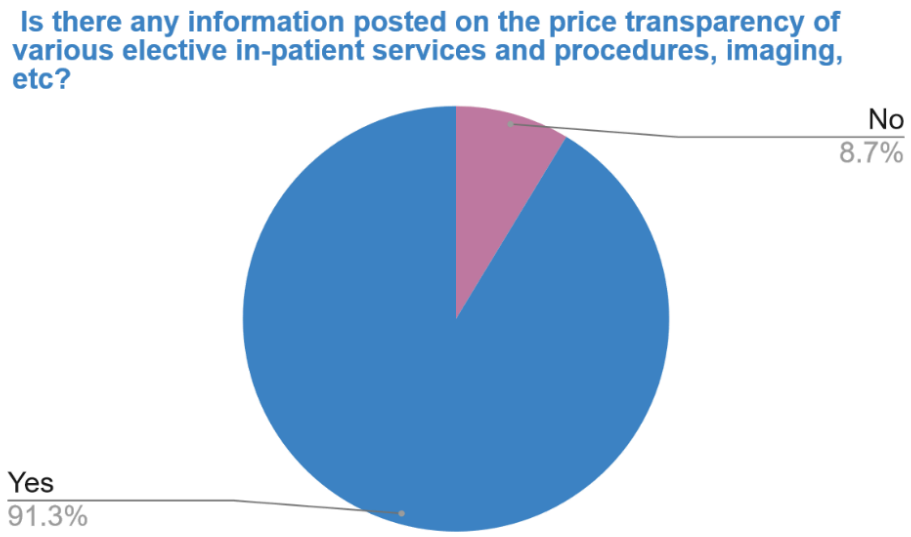
The Centers for Medicare and Medicaid recently also issued a ***Hospital Price Transparency Rule*** (HPTR) which became effective on January 1, 2021. The intent of the ***HPTR*** is, by requiring cost information to be made more transparent for consumers, to give people the ability to shop for the best-priced care. The hope is that the ability to shop for care will help control health care cost inflation. The need for consumers to have more accurate information about relative costs of elective care has also been a concern of the Tennessee General Assembly. In past sessions, both houses have explored different strategies—such as a statewide all-payers claims database—that would enable policymakers to monitor health care costs and consumers to make more informed economic decisions about their care.

The federal ***HPTR*** requires hospitals (and affiliated ambulatory surgical services) to post cost information in two formats:

1. A **downloadable, machine-readable, list of hospital charges** that is useful to health economists and health policy researchers in studying the complex logic of health care costs and pricing. The list must also include the discounts negotiated with each hospital as part of their participation in various insurance networks, as well as the discount that is given to uninsured patients if they are able to pay in cash.
2. A list of "***shoppable services" in a consumer-friendly manner***. Most hospitals we surveyed opted for a "cost-estimator tool", which enables a potential patient to estimate how much a needed operation or procedure might cost them, given the terms of their health insurance policy and barring complications that could not be foreseen.

While there was more consistency in where the "price transparency" link to information was posted, (CMS regulations require a link to be posted in the footer of the homepage of hospital websites), the cost estimator tools themselves varied in how difficult it was for consumers to use them.

Some cost estimator tools were inaccessible to our volunteers because they required a user to already be a patient of a hospital to access the tool. The tools also varied in the ways procedures were listed for consumers. Some estimator tools used broad categories, like "surgery" or "imaging", to list verbal descriptions of common procedures, but provided no options for a patient to search if a needed procedure was not listed. The number of procedures listed in this way also varied among hospitals. This might have been because some hospitals offered more procedures than others, but that was not clear to consumers.



Other estimator tools required technically specific information on prospective procedures and current insurance policies. For example, one tool listed eight different codes for a CAT scan of abdomen, six for a colonoscopy, and eleven for an MRI of the brain. Some tools were searchable by specific CPT (Current Procedural Terminology) codes, or Medicare DRG (Diagnostic Related Group) codes, but few patients would know to ask their providers for these codes. Nearly all the tools also presumed that users would also be able to provide detailed information about their health insurance policies, including the current balance of their deductibles and the amount of copayment or coinsurance applied to a prospective procedure. It would take an exceptionally well-informed and persistent consumer to use these tools effectively.

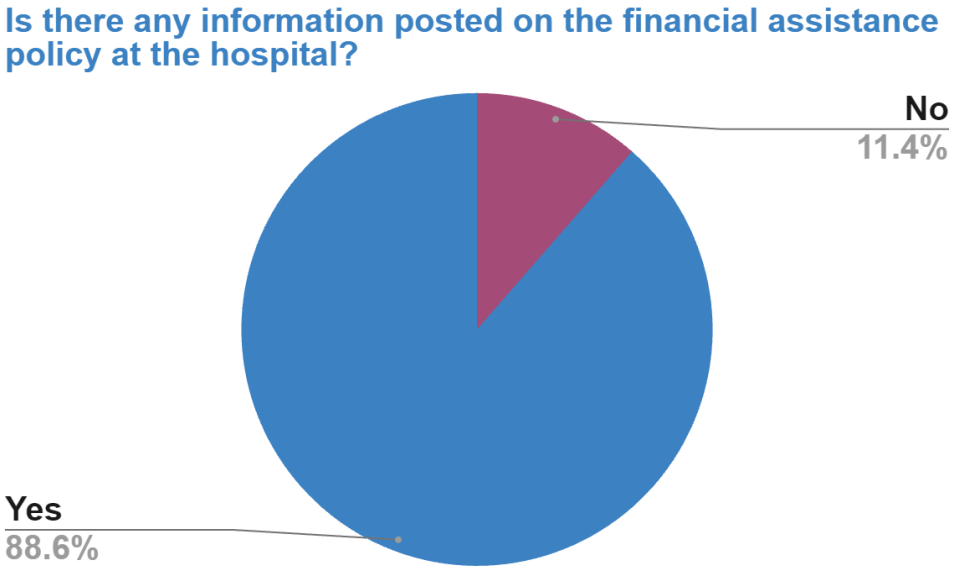
Estimator tools typically were introduced with lengthy disclaimers that not all provider or facility charges might be included in the estimate, so it was difficult to make comparisons between one hospital's tool and another's. For example, a THCC volunteer selected seven random hospitals to survey for the cost of a "knee arthroscopy with meniscus surgery" [CPT Code 29881], a relatively common procedure that can be done out-patient in most hospitals and ambulatory surgical settings. One hospital required that estimator tool users be registered patients. Another hospital allowed the volunteer to seek an estimate but would not report the estimate unless the "shopper" called their finance office for more information. A third hospital did not have arthroscopic knee surgery on their searchable list of procedures. The volunteer was able to obtain an estimate at the remaining four hospitals and saw a wide range of pricing, as shown in the following chart.

If the purpose of the estimator tools is to enable price comparison “shopping”, then clearly a more consistent policy on what costs to include needs to be adopted either through federal regulation or state legislation.

CPT 29881-KNEE ARTHROSCOPIC W/MENISCUS SURGERY	HOSPITAL A	HOSPITAL B	HOSPITAL C	HOSPITAL D
Total Cost	$39,880.00	$26,369.00	$17,243.00	$2,912.00
Self-pay discount	$27,118.00	none noted	$12,932.00	$1,340.00
Patient cost estimate	$12,762.00	$26,369.00	$4,310.00	$1,572.00

FINANCIAL ASSISTANCE POLICIES

The final question on the survey was regarding the financial assistance policy of the hospital. Volunteers were surprised to see that not every hospital website provided this information, although a patient could usually find a phone number to call to make inquiries. Again, there was a wide range in the detail of information provided on the websites, from a brief paragraph announcing there was a financial assistance policy, to detailed policy statements in multiple languages that could be downloaded along with downloadable application forms in multiple languages. Some policies only applied if a patient earned under 100% of the federal policy level, and others were much more generous. This is an area that THCC hopes to explore in more detail in a future survey. It is THCC's position that all hospitals should provide a similar community benefit in the form of equitable financial assistance to uninsured or underinsured patients with limited incomes.



DISCUSSION

The ***No Surprises Act (NSA)*** provides crucial protections for patients against unexpected bills from out-of-network providers in emergency situations and when patients seek care in an in-network hospital, hospital outpatient centers, or ambulatory surgery centers. The ***NSA*** also allows states to enact even broader protections, such as restricting balance billing by ground ambulance services, and grants states the flexibility to develop alternative mechanisms for resolving payment disputes between insurers and out-of-network providers. Most media and state enforcement attention has been focused on provider concerns because of numerous lawsuits over the dispute resolution process created at the federal level. THCC is concerned that not enough emphasis has been placed on whether patients fully understand their new rights and how to exercise them, or on the underlying problems of insurance network adequacy.

THCC undertook this survey of hospital websites to determine if they provided adequate information about consumer rights under the ***NSA.*** We found that while required information about ***NSA*** rights was usually posted, it was not placed in locations where patients would readily find it or was incomplete in that it did not fully explain protections for uninsured patients. THCC also investigated the related issues of whether patients had ready access to data on the costs of their care under the ***Hospital Price Transparency Rule,*** and to information about how they could obtain financial assistance when needed. In most cases this information was available, but there is room for improving its accessibility for more health care consumers.

The recommendations that follow are made in the hope that Tennessee hospitals will voluntarily work on improving the quality, transparency, and accessibility of the information they provide their service communities about their providers' networks, their charges, and the financial assistance they provide.

THCC recognizes that having ***NSA*** information on a website does not necessarily translate into patients receiving estimates about the cost of elective procedures or information about the network affiliations of providers in time to avoid balance billing or surprises in the amounts they are billed THCC will continue to work with providers, policy makers, TDCI and CMS to ensure that new health consumer rights are being respected and facilitated across our state. THCC urges Tennessee consumers who see this report to contact THCC if you feel your rights have been ignored or violated in any way at advocacy@tnhealthcarecampaign.org

RECOMMENDATIONS

THCC offers the following recommendations to Tennessee hospitals to improve access to information about new consumer rights and protections. We also look forward to finding ways to work more closely with policymakers and stakeholders to extend balance billing protections to ground ambulance services, to improve provider network adequacy, and to ensuring the accessibility and affordability of care for all Tennesseans.

The Tennessee Health Care Campaign recommends that Tennessee hospitals:

1. **Standardize the location and quality of the information available to consumers about their balance billing protections, right to a good faith estimate, right to file complaints with both state and federal agencies, eligibility for financial assistance, right to transparent pricing information, and that the hospitals provide this information in multiple languages.**
2. **Ensure that potential patients have access to comparable cost estimator tools by ensuring access through a guest portal.**
3. **Post detailed information about each hospital's financial assistance policies' eligibility criteria and application processes in multiple languages and as downloadable forms.**
4. **Expand current listings of patient rights and responsibilities to include the new rights to be protected from balance billing and to price transparency.**
5. **Provide TDCI with the resources to undertake a study to evaluate the consistency with which patients are receiving Advance Explanations of Benefits and good faith estimates in advance of their care and to support consumers through complaint procedures.**

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ADDITIONAL RESOURCES

For more information about the No Surprises Act and its implementation, we encourage Tennessee consumers to please visit the websites listed below.

Centers for Medicare and Medicaid: https://www.cms.gov/medical-bill-rights

Tennessee Department of Commerce and Insurance: https://www.tn.gov/commerce/blog/2022/1/12/the-no-surprises-act-will-protect-tennessee-consumers.html

Families USA: https://familiesusa.org/?s=No+Surprises+Act

Urban Institute: https://www.urban.org/sites/default/files/2023-04/No%20Surprises%20Act%20Perspectives%20on%20the%20Status%20of%20the%20Consumer%20Protections%20Against%20Balance%20Billing.pdf

Tennessee Health Care Campaign: https://tnhealthcarecampaign.org

Information on the Hospital Price Transparency Rule can be found here:

https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency

https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-E/part-180

Information on Tennessee Department of Commerce and Insurance Consumer Protection Services can be found here:

https://www.tn.gov/commerce/insurance/consumer-resources.html

We urge any Tennessee consumers who have received balance bills when they shouldn't have, or who have received balance bills for ground ambulance services which are not currently covered by the No Surprises Act or state law, to share your story with the Tennessee Health Care Campaign by calling us at our

Enrollment Hotline: 844-644-5443 or emailing advocacy@tnhealthcarecampaign.org.