North Carolina Law Conflicts with Federal Price Transparency Laws and Regulations

EXECUTIVE SUMMARY · 06/21/2022

North Carolina law appears to conflict with requirements in both the federal Transparency in Coverage Rule and the prohibition of gag clauses in the No Surprises Act and should immediately be revised or repealed.

Recent significant changes to federal healthcare price transparency law and regulation require some states to update their laws to permit price information sharing. Some states had no price transparency laws on the books. But others have laws that restrict sharing of pricing information or limit how it is used which now conflict with these new federal rules and laws. States with conflicting law must update their law or face legal risk that their laws will be found invalid for conflicting with federal law.

Both the Trump and Biden administrations have shown a bipartisan commitment to these new rules and laws, and hospitals have already lost their legal challenge to one set of price transparency regulations. Thus, the current price transparency framework is likely to remain binding, and states should align their laws.

The hospital price transparency rule is now in effect, and the tri-agency insurer price transparency rule will be fully implemented over the next couple of years starting on July 1st, 2022. On that day, insurer negotiated rates must be made available to the public, including discounted cash rates and historical prices of out-of-network payments. North Carolina laws that restrict the use of price transparency data by the State Plan will conflict with the federal regulations.

Federal law now also prohibits "gag clauses" that restrict the provision of "provider-specific cost" information, which can inform several activities including helping patients better shop, third parties to build shopping tools, or in rate negotiations between group health plans and providers or health systems. North Carolina law appears to mandate such gag clauses in State Health Plan-claims processor contracts that restrict the disclosure and use of "claim payment data". North Carolina should revise its laws to comply with federal law.

Question: Does North Carolina's law that limits the use and disclosure of prices violate the federal bar on gag clauses from the Consolidated Appropriations Act of 2021?

Short Answer: Yes.

North Carolina law currently limits the disclosure of cost and quality information and medical records, including the state employee health plan claims processor's negotiated rates and claims data. N.C. Gen. Stat. § 135-48.32(a) mandates that the benefits of the State Health Plan—the core of the Plan—shall be provided through contracts between the State Health Plan and claims processors and that these contracts must comply with applicable law governing the Plan. Applicable state law clearly includes N.C. Gen. Stat. §§ 135-48.32(b)-(g), and by law Plan-claims processor contracts must conform to these provisions. Sections 135-48.32(b) and (d)-(f) allow the claims processors (the business retained by the state plan to administer the program) to directly or indirectly hold back their negotiated rates and claims data with third party providers and further restricts the provision of data if the State Health Plan uses it for anything other than the "administration" of the plan. Data is further restricted if the State Health Plan seeks to provide data to negotiate prices or does not obtain explicit permission from the Claims Processor for each disclosure to third parties and every use of disclosed data.

This statute appears to violate the federal ban on gag clauses as well as federal price transparency requirements. Because federal law displaces any conflicting state law, these provisions would be vulnerable to legal challenge if not repealed. First, Section 201 of the Consolidated Appropriations Act bars any agreement that would restrict "providing provider-specific cost or quality of care information or data."[1] North Carolina's limitation on sharing claim payment data violates this federal ban.

In addition, federal price transparency regulations require "plans and issuers to disclose provider in-network rates, historical data on out-of-network allowed amounts, and negotiated rates and historical net prices for prescription drugs."[2] Again, North Carolina's limitation on sharing pricing information likely violates these federal regulatory requirements.
Note: The more detailed memorandum below identifies the key language in the relevant statutes. It was not prepared by a North Carolina attorney and is included to identify the pathways for final research.

[1] CAA § 201.
[2] 45 C.F.R 147, 158

Consolidated Appropriations Act (CAA)[3]

Enacted on Dec. 27, 2020,[4] the Consolidated Appropriations Act, 2021 (CAA) amends the Public Health Services Act.[5] The CAA prohibits health plans from entering into agreements, which "impose certain restrictions on the plan's access and ability to share information about the cost and quality of care."[6] Specifically mentioned are "claim-related financial obligations included in the provider contract."[7]

Division BB is entitled "Private Health Insurance and Public Health Provisions." Relevant here are Division BB's Title I "No Surprises Act," and Title II "Transparency."

Transparency

A gag clause is a "contractual agreement in which providers and insurers agree not to disclose prices, including negotiated rates from patients or plan sponsors."[8] **Section 201**[9] contains a Gag Clause Prohibition (GCP). The GCP bars direct or indirect limits on data sharing and prohibits a health plan from entering into an agreement that would directly or indirectly restrict "providing **provider-specific cost** or quality of care information or data."[10]

The CAA[11] works in tandem with other federal transparency requirements[12] such as the Hospital Price Transparency Rule,[13] the Transparency in Coverage Rule,[14] and the Health Insurance Reform, Transparency in Coverage.[15] The CAA must also be read in conjunction with ERISA and the Internal Revenue Code.

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3 Pub. L. 116-260 (Dec. 27, 2020).

4 Pub. L. 116-260 (Dec. 27, 2020).

5 45 CFR 147.

6 G'Nece Jones & Edward Leeds, Prohibition Against Gag Clauses, JDSupra (Ballard Spahr) (Jan. 31, 2022). https://www.jdsupra.com/legalnews/prohibition-against-gag-clauses-7562334/. (Jones & Leeds, Prohibition).

7 CAA §201(1)(B)(i).

8 Katherine Gudiksen, et al, *Mitigating the Price Impacts of Health Care Provider Consolidation*, Millbank Memorial Fund Issue Brief (Sept. 2021). https://www.milbank.org/wp-content/uploads/2021/09/Mitigating-the-Price-Impacts-of-Health-Care-Provider-Consolidation_2.pdf.

9 §201 is quoted, in part, at the end of this paper.

10 §201. One exception is data covered by federal privacy requirements. Thus health plans still need to comply with the privacy requirements of Acts such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Genetic Information Nondiscrimination Act (GINA), and the Americans with Disabilities Act (ADA) (see CAA Division BB §201).

11 There are three phases to CAA's transparency regulations. Under phase one, health plans must publicly post "in-network rates, out-of-network allowed amounts and billed charges, and prescription drug negotiated rates and historical prices." Phases two and three require a consumer computer price-estimator tool. See Edward I. Leeds & G'Nece Jones, Understanding the New Health Care Transparency Requirements, Ballard Spahr (Jan. 24, 2022). https://www.ballardspahr.com/Insights/Alerts-and-Articles/2022/01/Understanding-the-New-Health-Care-Transparency-Requirements. (Leeds & Jones, Understanding).

12 For some interesting articles regarding hospitals' compliance with transparency regulations, *see e.g.* Suhas Gondi, et. al., *Early hospital compliance with federal requirements for price transparency*, JAMA Intern Med. (Research Letter, June 14, 2021). https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2781019; and Morgan A. Henderson & Morgane C. Mouslim, *Low compliance from big hospitals on CMS's Hospital Price Transparency Rule*, Health Affairs Blog (Mar. 16, 2021). https://www.healthaffairs.org.

13 45 C.F.R. § 180.40 to § 180.60 (2019).

14 45 C.F.R. § 156.220 (2019).

15 45 C.F.R § 147.210, 211, and 212.

Each year, health plans must attest "to their compliance with the new requirements."[16] The above rules apply to virtually all plans "including self-insured, non-Federal governmental group health plans as defined in section 2791 of the PHS Act."[17] The rule goes on to require, " plans and issuers to disclose provider in-network rates, historical data on out-of-network allowed amounts, and negotiated rates and historical net prices for prescription drugs through digital files in a machine-readable format posted publicly on an internet website. Since Federal law is "supreme" under the U.S. Constitution, such Federal standards developed under section 2715A of the Public Health Service Act (PHS Act) preempt any related state standards that require pricing information to be disclosed to the participant, beneficiary, or enrollee, or otherwise publicly disclosed, to the ex."

North Carolina Law

Chapter 135, Art. 3B of the North Carolina General Statutes is entitled "State Health Plan for Teachers and State Employees." N.C. Gen. Stat. § 135-48.32(b) requires that Claims Processors provide a Claims Data Feed that includes all claim payment data at least once per month to the State Health Plan. But that same subsection also permits the Claims Processor to hold back "Claim Payment Data that reflects **rates negotiated with or agreed to by a noncontracted third party.**"[18] Additional subsections further limit how the State Health Plan can use the data it receives. § 135-48.32(d) forbids the State Health Plan from using these data for anything other than operation and administration of the plan, and forbids disclosure.[19] § 135-48.32(e) restricts the Plan from using these disclosures to negotiate rates. And § 135-48.32(f) requires the Plan to obtain explicit permission for every party to whom these rates would be disclosed *and* for every use that third party would have for the data.

The Centers for Medicare & Medicaid Services (CMS) sent states a comprehensive "state enforcement survey"[20] to determine states' ability to comply with Division BB of the CAA. CMS describes the gag policy removal as follows:

> Group health plans and issuers offering group health insurance coverage are prohibited from entering into agreements with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that restrict the plan or issuer from sharing provider-specific cost or quality of care information to referring providers, the plan

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16 Jones & Leeds, Prohibition.

17 45 C.F.R § 147, 158

18 §135-48.32(b) (emphasis added). ("(b) Unless otherwise directed by the Plan, each Claims Processor shall provide the Plan with a **Claims Data Feed**, which includes all Claim Payment Data, at a frequency agreed to by the Plan and the Claims Processor. The frequency shall be **no less than monthly**. The Claims Processor is **not required to disclose** Claim Payment Data that reflects **rates negotiated with or agreed to by a noncontracted third party** but, upon request, shall provide to the Plan sufficient documentation to support the payment of claims for which Claim Payment Data is withheld on such basis.") (emphasis added)

19 §135-48.32(d) (The Plan may use and disclose Claim Payment Data **solely for the purpose of administering and operating the State Health Plan** for Teachers and State Employees in accordance with G.S. 135-48.2 and the provisions of this Article. The Plan shall not make any use or disclosure of Claim Payment Data that would compromise the proprietary nature of the data or, as applicable, its status as a trade secret, or otherwise misappropriate the data. (emphasis added).

20 *State Enforcement Survey,* CMS (x/x/xx). https://www.google.com/search?q=state+complaince+with+CAA+health+plan&rlz=1C1GCEV_en&oq=state+complaince+with+CAA+health+plan&aqs=chrome..69i57j33i10i160l2.7601j0j4&sourceid=chrome&ie=UTF-8. Pages 11-12 deal with removing gag clauses.

> sponsor, enrollees, or prospective enrollees; electronically accessing de-identified claims and encounter information for each enrollee in compliance with federal privacy laws; or sharing such information or directing that it be shared with a business associate.[21]

On Dec. 27, 2021, CMS sent a letter to North Carolina.[22] In the letter, CMS states that it has "agreed to enter into a collaborative enforcement agreement with North Carolina to enforce certain provisions of the Public Health Service Act (PHS Act) as extended or added by the Consolidated Appropriations Act, 2021 (CAA) with respect to health insurance issuers, health care providers and facilities, and providers of air ambulance services."[23] CMS also acknowledges that "the North Carolina Department of Insurance expressed interest in entering into a collaborative enforcement agreement with CMS to enforce these provisions."[24]

Use and Disclosure of Health Care Prices

The National Conference of State Legislatures (NCSL) summarized the CAA's requirements as follows:[25]

> The final rule requires most private health insurance plans to provide patients out-of-pocket costs and negotiated rate information for health care items and services upon a patient's requests. Additionally, private health insurers must post three separate machine-readable files with information relating to negotiated rates with in-network providers, billed charges and allowed amounts from out-of-network providers, and negotiated rates and historical net prices for prescription drugs. Requirements to post machine-readable files go into effect January 2022 and cost-estimate requirements go into effect January 2024.[26]

The U.S. Dept. of Labor issued FAQs about Division BB.[27] DOL clarifies that health "plans and issuers must make public machine-readable files disclosing in-network rates and out-of-network allowed amounts and billed charges."[28] It further notes that the gag prohibition clauses are self-implementing.

> The statutory language of section 201 of division BB of the CAA is self-implementing, and the Departments do not expect to issue regulations on gag clauses at this time. Until any further guidance is issued, plans and issuers are expected to implement the requirements prohibiting gag clauses using a good faith, reasonable interpretation of the statute. However, the Departments intend to issue

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21 Id. p. 12.

22 Letter can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA-Enforcement-Letters-North-Carolina.pdf

23 *Id.*

24 *Id.*

25 "Transparency and Disclosure of Health Care Prices," NCSL (Sept. 7, 2021). https://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx.

26 *Id.*

27 *FAQs About Affordable Care Act And Consolidated Appropriations Act, 2021 Implementation Part 49*, U.S. Dept. Labor (Aug. 20, 2021).

28 Dept. of Labor FAQs.

implementation guidance to explain how plans and issuers should submit their attestations of compliance and anticipate beginning to collect attestations starting in 2022.[29]

In summary, these provisions and communication all make it clear that price transparency is required by federal law and North Carolina should update its state laws to be in compliance.

Economic Reasons to Update Price Transparency Laws

In addition to the legal risk North Carolina may face, there are economic reasons to update North Carolina's price transparency statutes to align with federal law. Some of those reasons include:

- Healthcare provider "consolidation is a primary driver of high and increasing health care costs in the United States."[30]
- Healthcare costs remain a major economic challenge concern for small businesses, which historically create the majority of new jobs.[31]
- "[R]ising out-of-pocket costs are a driver of health care disparities."[32]
- "[E]nhanced integration of health plan data into electronic health record (EHR) systems would allow for the real-time calculation of out-of-pocket costs for specific services."[33]
- '[T]imely, personalized estimates of patients' out-of-pocket health care costs can assist patients and clinicians in achieving greater value."[34]
- Blockchain data management could reduce unnecessary administrative costs.[35]
- Blockchain data management could save billions of dollars per year in data breach-related costs[36]

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29 Dept. of Labor FAQ.

30 Gudiksen et al 1.

31 Erika Gonzalez, *Health care costs threaten the future of small businesses that survive COVID*, The Hill (2021) https://thehill.com/blogs/congress-blog/healthcare/542550-health-care-costs-threaten-the-future-of-small-businesses-that/

32 Jeffrey T. Kullgren & A. Mark Fendrick, *The price will be right—how to help patients and providers benefit from the new CMS transparency rule*. JAMA Health Forum (2021). https://jamanetwork.com/journals/jama-health-forum/fullarticle/2776818.

33 Kullgren.

34 *Id.*

35 Yagoob et al.

36 Yaqoob et al.

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Hospital Price Transparency Rule, 45 C.F.R. § 180.40 to § 180.60 (2019).
Public Health Services Act 45 C.F.R. §147.210.
Transparency in Coverage Rule, 45 C.F.R. § 156.220 (2019).

Section 201

"(a) PHSA.--Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added and amended by title I, is further amended by adding at the end the following:
``SEC. 2799A-9. <<NOTE: 42 USC 300gg-119.>> INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION. (a) Increasing Price and Quality Transparency for Plan Sponsors and Group and Individual Market Consumers.-- (1) Group health plans.--A group health plan or health insurance issuer offering group health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from-- (A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees of the plan or coverage; (B) electronically accessing de-identified claims . . . consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis-- (i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract; (ii) provider information, including name and clinical designation; (iii) service codes; or (iv) any other data element included in claim or encounter transactions . . . .