COMPLIANCE ALERT

Alliant EMPLOYEE BENEFITS

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Departments Release Final Health Plan Pricing Transparency Regulations

Introduction

On October 29, 2020, the Departments of Health and Human Services, Treasury, and Labor (the Departments) issued their final rule on transparency in health plan coverage. The rule imposes new transparency requirements on all group health plans and health insurers in the individual and group markets. The transparency rule stems from an executive order on health care price and transparency that was issued by President Trump in June 2019. The Departments issued the proposed transparency rule in November 2019. The transparency rule also complements a similar hospital transparency rule issued earlier by HHS that requires hospitals to post standard charge information based on negotiated rates for common items or services (effective on January 1, 2021, pending a decision on the rule's validity by the D.C. Circuit Court of Appeals).

The final rule on transparency in health plan coverage generally has two parts. First, insurers and all non-grandfathered group health plans must provide cost-sharing information to enrolled individuals through an online tool on their website and in paper form. This part of the rule will be phased in and is fully effective in 2024. Second, they must publicly disclose pricing information in three machine-readable files for: (1) rates for in-network providers, (2) billed charges and allowed amounts for out-of-network providers, and (3) in-network prices for prescription drugs. This part of the rule will go into effect in 2022.

The final rule does not apply to grandfathered plans, excepted benefits, or account based plans like HRAs or H-FSAs. It does apply to all other group health plans, including church plans and non-federal governmental plans, as well as prescription drug plans.

For insured plans, these requirements are the responsibility of the carrier. For self-funded plans, compliance with these rules remains the obligation of the plan. It will be critical for employers sponsoring self-funded plans to amend contracts with Third Party Administrators (TPAs) to meet these requirements on behalf of the plan. This may also require TPAs to amend their contracts with certain providers or adjust how they categorize claims (to be "in-network" a plan or TPA must have a specific contract with a provider accepting a specific rate or reimbursement that will not result in balance billing). Employers sponsoring level funded plans should immediately confirm funding status and address which party has this responsibility.

Disclosure of Cost-Sharing Information to Enrollees on Request

Upon request, plans and insurers must disclose to current plan participants and beneficiaries (enrollees) estimates of cost-sharing for covered health care items and services from a particular provider. Items or services include encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees (including facility fees). The goal is to enable enrollees (or their representatives), to obtain an estimate of out-of-pocket expenses in advance.

As noted above, this disclosure requirement will be phased in. Cost-sharing information must be available for 500 listed items and services beginning in 2023 with information for all items and services available beginning in 2024. The Departments identify the 500 items and services (along with a plain language

description and CPT code) in the preamble of the final rule. This disclosure is based on the structure of current explanation of benefits (EOB) notices. EOBs disclose a wide array of information including the amount billed, the in-network negotiated rate, allowed amounts for out-of-network providers, and the individual's cost-sharing obligations. But unlike EOBs, which are provided to patients after services have been delivered, this advanced disclosure should help enrollees choose more cost effective options. The Departments acknowledge cost-sharing data will only be an estimate and will not necessarily reflect the amount that a patient is ultimately charged.

Required Disclosure Content

The final rule outlines seven content elements that a plan or insurer must disclose, upon request, to an individual.

(1) Estimated Cost Share Liability. This is an estimate of the amount that the individual would be responsible for paying under the plan's specific deductible, coinsurance, and copay structure. The estimated liability must be based on actual rates, allowed amounts, and individual-specific cost-sharing limits. It should also reflect any cost-sharing reductions. This estimate does not include premiums, balance billing amounts for out-of-network providers, or the cost of non-covered items or services.

(2) Accumulated Amounts. This is the amount of cost-sharing that the individual (or family) has already paid towards the plan's deductible or out-of-pocket maximum. The accumulated amount should also reflect any progress towards reaching a treatment limit (such as providing cost-sharing information based on the number of physical therapy visits already used relative to the plan's cap on the number of visits for physical therapy that could be covered).

(3) In-Network Rates. Where plans have specifically negotiated contract rates with specific providers those must be disclosed (note that balance billing is generally not permitted in-network). The Departments will require the disclosure of an in-network rate even if that rate does not impact the individual's cost-sharing liability. If the plan or insurer has no contractually agreed to rates or underlying fee schedule rates, it does not technically have a network and this element does not apply. If a plan has specifically negotiated an in-network rate with a provider as a percentage of Medicare or other formula the plan must disclose rates and fee schedules that result from such a formula as a specific dollar amount. With respect to prescription drug plans, cost sharing estimates provided through a standalone tool offered by a PBM or TPA will satisfy this element.

(4) Out-of-Network Allowed Amounts. This is the allowed amount that a plan or insurer would pay for a covered item or service furnished by an out-of-network provider or any other calculation that provides a *more accurate* estimate of the amount the plan would pay (such as usual, customary, and reasonable rates). Again, this does not include balance billing amounts but if a plan uses a percentage of Medicare or other fixed formula the plan must disclose rates and fee schedules that result from such a formula as a specific dollar amount. A percentage can be disclosed instead of a dollar amount only if a plan reimburses out-of-network providers a percentage of *billed* charges.

(5) Items and Services Content List for a Bundled Payment. This is a list of all covered items and services reflected in the cost-sharing estimate for a bundled payment arrangement. Plans and insurers do not have to list cost-sharing information separately for each covered item or service in the bundle.

(6) Notice of any Prerequisites to Coverage. Plans and insurers must inform individuals that they may need to satisfy certain medical management techniques before the item or service will be covered. This list is limited to concurrent review, prior authorization, and step-therapy or fail-first protocols.

(7) Disclosure Notice. This is a plain language notice that must include specific disclosures to inform individuals: (1) about the possibility of out-of-network balance billing that is not reflected in the cost-sharing estimate, (2) that actual cost-sharing may differ from the estimate, (3) that a cost-sharing estimate is

not a guarantee of coverage, (4) whether copay assistance and other third-party payments count towards cost-sharing limits, and (5) that a recommended preventive service may be subject to cost-sharing if not billed as a preventive item or service. The balance billing statement is only required if balance billing is permitted under state law (balance billing is banned under some state insurance codes but this will be required for self-funded plans that cover out-of-network care). The final rule provides model language.

Methods of Disclosure

Under the final rule, plans and insurers will be required to disclose real-time cost-sharing estimates in two ways, through a user-friendly online self-service tool and on paper.

The online self-service tool must allow users to search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers by inputting: (1) a billing code (such as CPT[1] code 87804) or a descriptive term (such as "rapid flu test"), at the option of the user, (2) the name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider, and (3) other factors utilized by the plan or insurer that are relevant for determining the applicable cost-sharing information (such as location of service, facility name, or dosage).

It must allow users to search for an out-of-network allowed amount, percentage of billed charges, or other rate that provides a reasonably accurate estimate of the amount a plan or insurer will pay for a covered item or service provided by out-of-network providers by inputting: (1) a billing code or descriptive term, at the option of the user, and (2) other factors utilized by the plan or insurer that are relevant for determining the applicable out-of-network allowed amount or other rate (such as the location in which the covered item or service will be sought or provided).

Lastly, the tool must allow users to refine and reorder search results based on geographic proximity of in-network providers, and the amount of the participant's or beneficiary's estimated cost-sharing liability for the covered item or service.

With respect to paper disclosures, all of the same information must be made available in plain language, without a fee, in paper form at the request of the enrollee. In responding to such a request, the plan or insurer can limit the number of providers to no fewer than 20 per request. The plan or insurer is required to: (1) disclose the applicable provider-per-request limit to the participant or beneficiary, (2) provide the cost-sharing information in paper form pursuant to the individual's request, and (3) mail the cost-sharing information in paper form no later than 2 business days after an individual's request is received.

Public Disclosures of In-Network Rates and Out-of-Network Allowed Amounts

In addition to individual enrollee disclosures, plans and insurers must publicly post three machine-readable files: (1) a file on all in-network rates (including negotiated rates, underlying fee schedules, or derived amounts) with in-network providers for all covered items and services, (2) a file on out-of-network allowed amounts and billed charges for covered items and services provided by out-of-network providers, and (3) a file on in-network negotiated rates and historical prices for prescription drugs. The rule further identifies specific requirements for each file, summarized below. Information must be updated monthly and made publicly available on an insurer's or plan's website free of charge, without having to log-in or otherwise submit identifying information. This data is intended to allow employers to negotiate better pricing but could also be used by out-of-network providers to better understand what percentage of a billed amount they are likely to receive. All three machine-readable files must be made available beginning in 2022. Payers and provider will need to amend contracts that include gag clauses or non-disclosure agreements in advance of this deadline.

[1] Current Procedural Terminology.

(1) In-Network Rates. Where plans have contracts with providers creating in-network negotiated rates and reimbursements several data elements are required. First, plans and insurers must include their Health Insurance Oversight System ID (preferably at the 14-digit product level). If a plan or insurer does not have a HIOS ID, it must use the employer's EIN. Next, specific billing codes (generally CPT, HCPCS, DRG, or NDC coding)[2], with which providers, insurers and TPAs are all readily familiar. Lastly, all applicable rates and fee schedules must be reflected as dollar amounts for each covered item or service associated with every provider identified by their National Identifier and Place of Service Codes. This file would only include reference based pricing arrangements with a defined network (contracted providers accepting a specific rate or reimbursement that will not result in balance billing).

(2) Out-of-Network Billed and Allowed Amounts. Where plans cover items or services by providers without existing contractually agreed to rates, additional disclosures are required to reflect possible balance billing. As with the in-network file, this file must also include the plan's HIOS ID (preferably at the 14-digit product level) or the employer's EIN. Specific billing codes are also required and every provider must be identified by their National Identifier and Place of Service Codes. The additional disclosure required for the out-of-network file is historical data on billed charges and specific allowed amounts (the discrepancy is generally balance billed). The disclosure is specifically allowed amounts and billed charges covered for items or services furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date of the file.[3] All of a plan's allowed amounts must be reflected as actual dollar amounts (not as a percentage of either Medicare or an amount billed) to allow a direct comparison with a provider's billed amounts.

(3) In-Network Prescription Drugs. Where plans cover prescription drugs a separate file is required for negotiated rates for prescription drugs. As with both files above, this file must include the plan's HIOS ID or employer's EIN and the National Identifier and Place of Service Codes for each in network provider. However, only the NDC specified by the Food and Drug Administration is needed to identify a specific drug. All negotiated rates must be reflected as actual dollar amounts associated with each pharmacy or network provider. Like the file for out-of-network historical data, this file also requires historical data during the 90-day time period that begins 180 days prior to the publication date of the file that applies to each NDC. However, historical data here is to account for rebates, discounts and charge backs as opposed to balance billing.

MLR Calculations to Account for Shared Savings Programs

Lastly, the final rule included a change to the calculation of Medical Loss Ratio Rebates. The optional calculation change accommodates plans with benefit designs that encourage enrollees to shop for lower-cost, higher-value providers. If these designs result in savings, insurers can share in those savings by taking credit for "shared savings" in the numerator of their MLR calculation. This optional provision will go into effect with the 2020 MLR reporting year (i.e., data reported by July 31, 2021).

Conclusion

The final rule should greatly improve cost transparency in our health care system. Although there will be significant cost associated with implementation, the rule will ultimately help plans promote consumerism and cost savings. The rule should also help reduce the epidemic of surprise billing by clearly defining in and out-of-network providers, requiring a balance billing disclosure for out-of-network services, and by quantifying reference based pricing reimbursement amounts. Employers sponsoring self-funded plans

[2] Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code, National Drug Code (NDC).

[3] Plans and insurers may omit data in relation to a particular item or service and provider when the report of out-of-network allowed amounts would be for fewer than 20 different claims for payments under a single plan.

should reach out to their TPAs and/or PBMs to ensure compliance with both public and enrollee disclosure and transparency requirements.

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