Federal Agencies Issue Final Rules Addressing Transparency in Coverage

The Department of Health and Human Services (HHS), the Department of Labor, and the Department of Treasury (the "Agencies") issued final rules for Transparency in Coverage on October 29, 2020. HHS also posted a fact sheet summarizing these rules that were drafted in response to President Trump's June 2019 Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First.

The rules will provide health plan participants with greater access to health care cost information than is generally available or required today, but they impose a significant burden on insurance carriers and the sponsors of employer-provided medical plans. The rules also allow insurance carriers to affect their medical loss ratio calculations by using certain shared savings programs, but we will not address this in this Alert.

The Bottom Line

The rules affect both fully insured and self-insured health plans ("health plans"), and plan sponsors are generally responsible for meeting their requirements. A fully insured plan can contractually shift the compliance responsibility to the insurance carrier or another willing third party. The compliance responsibility remains with the plan sponsor for a self-insured plan, although most sponsors will contractually delegate administration to third party administrators (TPAs) out of practical necessity. The contract should provide indemnification protection to the plan sponsor for losses caused by the TPA.

The rules' main objective is to provide consumers (that's us) with real-time access to actual cost information, including estimated cost-sharing liability for services covered by the health plan through online tools. The Agencies believe this information is necessary for members to make informed decisions about health care, including their choice of health care providers.

When, Exactly?

The rules phase in over a three-year period to allow time to compile the necessary information and build the communication tools. Compliance with each phase is required for plan years beginning on or after the applicable date.

Phase 1: Plan years beginning on or after January 1, 2022

Plans must publicly disclose the following three machine-readable files on the insurance carrier or plan's website.

1. In-Network Rates – This file must include all applicable in-network provider rates for covered items and services, including negotiated rates, underlying fee schedules, and other derived amounts.

2. Out-of-Network Allowed Amounts – This file must provide the billed charges and allowed amounts for covered items and services provided by out-of-network providers over a 90-day period that begins 180 days before the file's publication date. For example, a file published on January 1, 2022 (required for calendar year plans) should reflect this data for a 90-day period beginning in early July 2021.
3. In-Network Prescription Drugs – This file must report the in-network negotiated rates and historical net prices for prescription drugs

The files must be updated monthly and provided free of charge. The insurance carrier and/or plan cannot require individuals to log in or provide identification to access the files.

Phase 2: Plan years beginning on or after January 1, 2023
Non-grandfathered plans[1] must provide participants with detailed personalized cost estimates for an initial list of 500 specified services through a self-service internet-based tool or in paper format upon request. This is the same information that generally appears in an explanation of benefits (EOB) after receiving services, and the rules essentially require plans to make this information available beforehand in a similar EOB-style format. Please see Required Cost Estimate Disclosures.

Phase 3: Plans beginning on or after January 1, 2024
Non-grandfathered plans must provide cost estimate information for all covered items and services.

Required Cost Estimate Disclosures

The required cost estimate information includes:

- The estimated cost-sharing liability, such as deductibles, coinsurance and copays a participant is responsible for paying for a covered item or service;
- The accumulated amounts applied to cost limits such as deductibles and out-of-pocket cost limits to date;
- The negotiated rate that the health plan agreed to pay for a service with an in-network provider;[2]
- The out-of-network allowed amount and the participant's cost sharing responsibility if the member goes to an out-of-network provider;
- If the service is part of a bundled payment agreement, all the services that are included in the bundled payment agreement;
- Whether the service is subject to any medical management procedures, such as concurrent review, prior authorization, step therapy, etc.; and
- Other disclosures, including:
    (1) Out of network providers may balance bill the participant;

[1] This refers to grandfathered status under the Affordable Care Act.
[2] This is not required if the negotiated rate does not affect the participant's estimated cost.

(2) Estimates may differ from the actual cost;

(3) Cost-sharing estimates are not a guarantee of coverage;

(4) Whether third party payment assistance will count toward cost sharing limits; and

(5) Preventive services may be subject to cost sharing if not billed as a preventive service or if provided outside preventive service guidelines.[3]

A draft model notice is available, but the language should be tailored to better fit the health plan without conflicting with the required language in the model notice. The notice must also be understandable by the average plan participant.

Cost Estimate Notice Delivery

The information must be available through a self-service internet-based tool – a mobile application should suffice – ***and*** by paper notice upon request. A paper notice must be provided at no charge within two (2) days of a request. Participants may agree to alternative delivery formats (e.g. telephone, email, in-person), but the notice content must still be provided within two (2) days of the request.

Note: A plan may limit cost estimate information to a maximum of twenty (20) health care providers per paper delivery request.

Reactions

We expect insurance carriers, TPAs, and price transparency vendors will challenge public access to network negotiated discounted fees based on the arguments that: (1) such information is proprietary; and (2) this will weaken competitive advantages which is the opposite effect intended by the Executive Order. Also, the existing proprietary systems used by most of these entities do not include all the information required by the rules meaning the entities will need to invest to update their tools.[4] In addition to affecting health plans, the rules may also affect health care providers by pressuring them to reduce and/or justify charges for services.

Note: In theory, transparency should lead to lower health plan costs if it causes participants to use lower cost, high quality providers. This might be offset to some extent if it also leads to participants seeking more health care.

[3] The final rules do not address health outcomes, but we expect insurance carriers, TPAs, and price transparency vendors will also provide this information.
[4] These expenses may pass through to health plans in the form of higher premiums or other fees.

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