Proposed Rules on Coverage Transparency and Final Rules on Hospital Price Transparency

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On November 15, 2019, the Internal Revenue Service (IRS), Department of Labor (DOL), and the Department of Health and Human Services (HHS) (collectively, Departments) released proposed rules on coverage transparency.

The proposed rules seek to give an estimate of plan participants' potential cost-sharing liability for covered items and services they might receive from a particular health care provider. The proposed rules require group health plans and insurance issuers in the individual and group markets to disclose cost-sharing information and negotiated rates.

The proposed rules would also allow issuers that encourage participants to shop for lower cost services to take credit for "shared savings" payments they provide to participants in their medical loss ratio (MLR) calculations. HHS released a fact sheet regarding the proposed rules.

The Departments also issued final rules on price transparency requirements for hospitals. The final rules establish requirements for hospitals to create, update, and make public a list of their standard charges, including payer-specific negotiated charges, for the items and services they provide. HHS released a fact sheet regarding the final rules.

The final rules on hospital price transparency are effective on January 1, 2021.

HHS issued a press release regarding the proposed rules and the final rules.

The proposed rules regarding disclosure of cost-sharing information and public disclosure of negotiated rates and allowed amounts would become effective for plan years beginning on or after one year after final rules are issued. The proposed rule regarding the medical loss ratio (MLR) calculation would become effective beginning with the 2020 MLR reporting year.

Public comment on the proposed rules is due on January 29, 2020. After considering public comments, the Departments will issue final rules.

Below is a summary of the coverage transparency proposed rules affecting group health plans and issuers.

Coverage Transparency Proposed Rules

Under the proposed rules, group health plans and health insurance issuers in the individual and group markets must disclose cost-sharing information in plain language for a covered item or service, including prescription drugs, from a particular provider or providers to participants, beneficiaries, or enrollees, upon request. This information must also be made available in paper form.

The cost-sharing amounts would be estimates and would not be required to include costs for unanticipated items or services that an individual could potentially incur due to the severity of an illness or injury, provider treatment decisions, or other unforeseen events.

The information required to be disclosed under the proposed rule does not go beyond what is currently disclosed in explanation of benefits (EOBs) that plans and issuers provide after services have been furnished and payment has been adjudicated. The difference is that, under the proposed rule, these estimates would be provided to plan participants before services are rendered.

Upon request by a participant, beneficiary, or enrollee, a plan or issuer must disclose the following seven items regarding a covered item or service:

1. Estimated cost-sharing liability – The amount a participant, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the plan or coverage.

2. Accumulated amounts – The amount of financial responsibility that a participant, beneficiary, or enrollee has incurred at the time the request for cost-sharing information is made, either with respect to a deductible or an out-of-pocket limit.

3. Negotiated rate – The amount a plan or issuer, or a third party (such as a third-party administrator (TPA)) on behalf of a plan or issuer, has contractually agreed to pay an in-network provider for a covered item or service according to the agreement between the provider and the plan, issuer, or third party on behalf of a plan or issuer. The negotiated rate's disclosure is not required if it is irrelevant in calculating an individual's cost-sharing liability for a particular item or service.

4. Out-of-network allowed amount – The maximum amount a plan or issuer would pay for a covered item or service furnished by an out-of-network provider. When disclosing an estimate of cost-sharing liability for an out-of-network item or service, the plan or issuer would disclose the out-of-network allowed amount and any cost-sharing liability the participant, beneficiary, or enrollee would be responsible for paying.

5. Items and services content list – A list of those covered items and services for which cost-sharing information is disclosed. This requirement would be relevant only when a participant, beneficiary, or enrollee requests cost-sharing information for an item or service that is subject to a bundled payment arrangement that includes multiple items or services, rather than one discrete item or service.

6. Notice of prerequisites to coverage – A notice informing the individual, when applicable, that a specific covered item or service for which the individual requests cost-sharing information may be subject to a prerequisite for coverage. Prerequisites to coverage include certain medical management techniques, such as concurrent review, prior authorization, and step-therapy, that must be satisfied before a plan or issuer will cover the item or service.

7. Disclosure notice – The disclosure notice must include three disclaimers:

    1) Out-of-network providers may bill participants, beneficiaries, or enrollees for the difference between providers' billed charges and the sum of the amount collected from the plan or issuer and the amount collected from the patient in the form of cost-sharing. The estimates do not account for those potential additional amounts.

    2) Actual charges for the participant's, beneficiary's, or enrollee's covered items and services may be different from those described in a cost-sharing liability estimate, depending on the actual items and services received at the point of care.

    3) The estimated cost-sharing liability for a covered item or service is not a guarantee that coverage will be provided for those items and services.

    Plans and issuers are permitted to include additional information as long as the information does not conflict with the information required to be provided in the notice. The Departments developed a proposed model notice that can be used to satisfy the disclosure notice requirement.

Required Methods for Disclosure

Under the proposed rules, the cost-sharing information described above must be disclosed using two methods: 1) an internet-based self-service tool and 2) in paper form.

Disclosure via internet-based self-service tool

The internet-based self-service tool must allow users to search for cost-sharing information for covered items and services. The 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. The tool must also allow users to search for the out-of-network allowed amount for a covered item or service provided by out-of-network providers.

The tool must provide users real-time responses that are based on cost-sharing information that is accurate at the time of the request. The tool must allow users to search for cost-sharing information by billing code or by descriptive term, or by a specific in-network provider's name in conjunction with a billing code or descriptive term. If a plan or issuer uses a multi-tiered network, the tool is required to produce the relevant cost-sharing information for the covered item or service for each tier.

To the extent that cost-sharing information for a covered item or service under a plan varies based on factors other than provider (for example, specific facility or prescription drug dosage), the tool must allow the user to input this information or the tool must display the different cost-sharing results based on the different factors.

Plans and issuers must also allow users to search for the out-of-network allowed amount for a covered item or service provided by out-of-network providers by inputting a billing code or descriptive term and the information necessary for the plan or issuer to produce the out-of-network allowed amount. The tool must allow users to sort and filter multiple results.

Disclosure via paper

Upon request by the participant, beneficiary, or enrollee, the cost-sharing information described above must be disclosed in paper form. Similar to the requirements for the internet-based self-service tool, the plan or issuer must allow an individual to request cost-sharing information for a discrete covered item or service by billing code or descriptive term.

The plan or issuer must provide cost-sharing information for a covered item or service in connection with an in-network provider or providers, or an out-of-network allowed amount for a covered item or service provided by an out-of-network provider, according to the participant's, beneficiary's, or enrollee's request, permitting the individual to specify the information necessary for the plan or issuer to provide meaningful cost-sharing information (such as prescription drug dosage or ZIP code for an out-of-network allowed amount).

The information must be mailed to the requesting participant, beneficiary, or enrollee no later than two business days after the request is received.

A group health plan and issuer may enter into a written agreement under which the issuer agrees to provide the required information described above. In this case, if the issuer fails to meet the requirements, the issuer, not the plan, is in violation of the proposed rules.

Public Disclosure of Negotiated Rates and Historical Allowed Amounts

The proposed rule requires group health plans and health insurance issuers to disclose to the public, through two machine-readable files (see below for a definition of "machine-readable file"), the negotiated rates for in-network providers and unique amounts a plan or issuer allowed for items or services furnished by out-of-network providers during a specified time period.

The files must be available on an Internet website and must be accessible free of charge, without having to establish a user account, password, or other credentials, and without having to submit any personal identifying information such as a name or email address. The information required to be included in each machine-readable file must be updated monthly and the files must clearly indicate the date when the information was last updated.

The first file (referred to as the Negotiated Rate File) must include information regarding rates negotiated with in-network providers. The DOL released a table of proposed data elements that a plan or issuer would be required to include in a Negotiated Rate File. The second file (referred to as the Allowed Amount File) must include historical data showing allowed amounts for covered items and services furnished by out-of-network providers. The DOL released a table of proposed data elements that a plan or issuer would be required to include in an Allowed Amount File. Both files must include three items:

1. The name and identifier for each plan option or coverage offered by a plan or issuer. For the identifier, plans and issuers use their Employer Identification Number (EIN) or Health Insurance Oversight System (HIOS) IDs, as applicable.

2. Any billing or other code used by the plan or issuer to identify items or services for purposes of claims adjudication, or accounting or billing for the item or service, including but not limited to, the Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the Diagnosis Related Group (DRG), the National Drug Code (NDC), or other common payer identifier used by a plan or issuer, such as hospital revenue codes, as applicable. Plain language descriptions must be included for each billing code.

3. Negotiated rates or out-of-network allowed amounts.

See Appendix A for an Allowed Amount File example from the proposed rules.

The proposed rules define “machine-readable file” to mean a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost. This means that the machine-readable file can be imported or read by a computer system without those processes resulting in alterations to the ways the data and the commands are presented in the machine-readable file.

Each machine-readable file must use a non-proprietary, open format to be identified by the Departments in technical implementation guidance (for example, JSON, XML, CSV) that will be published after the final rules are issued. A PDF file, for example, would not meet this definition due to its proprietary nature. The Departments will publish separate guidance to further describe the specific data elements that will be disclosed in the machine-readable files.

If plan coverage is offered through an issuer, the plan would satisfy the file requirement if the health insurance issuer offering the coverage is required to provide the information pursuant to a written agreement between the plan and issuer. If a plan sponsor and an issuer enter into a written agreement under which the issuer agrees to provide the information required under the proposed rules, and the issuer fails to provide full or timely information, then the issuer, not the plan, would violate the proposed rules.

A plan or issuer may satisfy the public disclosure requirement by entering into a written agreement under which another party (such as a TPA or health care claims clearinghouse) will make public the required information. However, if a plan or issuer chooses to enter into such an agreement and the party with which it contracts fails to provide full or timely information, the plan or issuer would violate the proposed rules.

Good Faith Safe Harbor

A plan or issuer will not fail to comply with the proposed rules described above, if acting in good faith and with reasonable diligence, the plan or issuer makes an error or omission in a disclosure, provided that the information is corrected as soon as practicable.

To the extent such error or omission is due to good faith reliance on information from another entity, the proposed rules include a special applicability provision that holds the plan or issuer harmless, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate.

A plan or issuer will not violate the proposed rules solely because, despite acting in good faith and with reasonable diligence, its Internet website is temporarily inaccessible, provided that the plan or issuer makes the information available as soon as practicable.

Shared Savings and the MLR Rule

HHS proposes to allow shared savings, when offered by an issuer, to be factored into an issuer’s MLR calculation beginning with the 2020 MLR reporting year. If a plan is designed to incentivize consumers to shop for services from lower cost, higher-value providers and the design results in savings, issuers can take credit for the “shared savings” payments made to participants in the numerator of the MLR calculation. Issuers would not be required to pay MLR rebates based on a plan design that provides a benefit to consumers that is not currently captured in any existing MLR revenue or expense category.

Applicability

The following types of plans and coverage aren't subject to the proposed rule: grandfathered health plans; excepted benefits; short-term, limited-duration insurance; or other account-based group health plans (FSAs, HSAs, and HRAs) that simply make certain dollar amounts available.

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Appendix A

Allowed Amount File Example

Assume Group Health Plan A intends to publish a machine-readable file on July 1 reporting the out-of-network historical allowed amount data. Group Health Plan A's Allowed Amount File must detail each discrete out-of-network allowed amount the plan calculated in connection with a covered item or service furnished by an out-of-network provider between January 1 and April 1. During this 90-day time period, Group Health Plan A paid 23 claims from Provider Z seeking compensation for rapid flu tests (CPT Code 87804), a service covered under the group health plan. Group Health Plan A calculated out-of-network allowed amounts of $100 for three claims, $150 for 10 claims, and $200 for the remaining 10 claims. Under these proposed rules, Group Health Plan A would report in the file published on June 30, that it calculated three different out-of-network allowed amounts of $100, $150, and $200 for rapid flu tests (CPT Code 87804) in connection with covered services furnished by Provider Z from January 1 to April 1. On July 30, Group Health Plan A would update the file to show the unique out-of-network allowed amounts for CPT Code 87804 for Provider Z's services rendered from February through April. On August 30, Group Health Plan A would update the file to show such payments for services rendered from March through May, and so on.