

Transparency in Coverage Proposed Rule

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Transparency in Coverage

- Background
- Internet-based, Self-service Tool for Disclosure of Cost-Sharing Information to Participants, Beneficiaries, or Enrollees
 - Cost-sharing data elements
 - Draft Model Notice
 - Internet-based, self-service tool
- Machine Readable Files for Public Disclosure of Negotiated Rates and Allowed Amounts for OON Providers
- Requests for Information

Background

Background: Transparency

- The proposed regulations were issued in response to White House executive order No. 13877, entitled “Improving Price and Quality Transparency in American Healthcare to Put Patients First”
- The proposed regulations would implement section 2715A of the Public Health Service Act (“PHS Act”) and section 1311(e)(3) of the Patient Protection and Affordable Care Act (“ACA”)

Background: Transparency

The stated purpose of the proposed regulations is to

“provide consumers with price and benefit information that will enable them to evaluate health care options and to make cost-conscious decisions; reduce surprises in relation to consumers’ out-of-pocket costs for health care services; create a competitive dynamic that will begin to narrow price differences for the same services in the same health care markets; foster innovation by providing industry the information necessary to support informed, price-conscious consumers in the health care market; and, over time, potentially lower overall health care costs”

Internet-Based, Self-Service Tool

Disclosure of Cost-Sharing Information

Require plans and issuers to disclose the following cost-sharing information *upon the request of a participant, beneficiary, or enrollee* (or authorized representative) through an internet-based, self-service tool:

- **Estimate of cost-sharing liability** for the covered item or service
- **Accumulated amounts** incurred to date
- **Negotiated rate** (reflected as a dollar amount) for an in-network provider for the covered item or service
- **Out-of-network allowed amount** for the covered item or service
- If a bundled payment arrangement, the list of the items or services
- Any **prerequisite** for the covered item or service

Requested information must be provided in paper form, free upon request and mailed no later than 2 business days after request is received

Cost-Sharing Liability Estimates

- “**Cost-sharing liability**” is 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
 - does not include premiums, balance billing amounts for OON providers, or the cost of non-covered items or services
- Must be built upon *actual* negotiated rates, OON allowed amounts, and *individual-specific* accumulated amounts, which must be accurate at the time of request
- Data elements are required to be disclosed *only* to the extent relevant to the cost-sharing liability
- “**Items or services**” means *all* encounters, procedures, medical tests, supplies, drugs, DME, and fees (including facility fees) in connection with the provision of health care

Accumulated Amounts

- “**Accumulated amounts**” means 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 a MOOP limit
 - If family coverage, the accumulated amounts include amounts an individual has incurred toward individual deductible and/or MOOP limit *and* amount individuals enrolled under the plan or coverage incurred toward family deductible and/or MOOP limit
- “Accumulated amounts” include an individual’s progress toward meeting a specific cumulative treatment limitation on a covered item or service (e.g., limits on items, days, units, visits, or hours covered in a defined time period)

Negotiated Rates

- The proposed rules would require plans and issuers to disclose certain “negotiated rates”
- “**Negotiated rate**” means the amount a plan or issuer, or a TPA, has contractually agreed to pay an in-network provider for a covered item or service pursuant to the terms of an agreement between the provider and the plan, issuer, or TPA
 - *Only* required to be disclosed where the “negotiated rate” is necessary for an individual to determine cost-sharing liability for a covered in-network item or service
 - Must be reflected as a dollar amount
 - Includes prescription drugs (*Note: Departments request comment on whether a rate other than the “negotiated rate,” such as the undiscounted price, should be required to be disclosed, and whether and how to account for any and all rebates, discounts, and dispensing fees*)

Out-of-Network Allowed Amount

- Require disclosure of the plan’s “out-of-network allowed amount” when a participant, beneficiary, or enrollee requests cost-sharing information for a covered item or service furnished by an OON provider
- **“Out-of-network allowed amount”** means the maximum amount a plan or issuer would pay for a covered item or service furnished by an OON provider
 - Only required to be disclosed where the OON allowed amount is necessary for an individual to determine cost-sharing liability for a covered item or service
 - This disclosure would not include any potential balance billing amounts owed by the participant to the OON provider

Prerequisite for Coverage

- Require disclosure that a specific covered item or service is subject to a “prerequisite” for coverage
- **“Prerequisite”** means certain requirements relating to medical management techniques for covered items and services that must be satisfied before a plan or issuer will cover the item or service
 - Prerequisites include concurrent review, prior authorization, and step-therapy or fail-first protocols
 - Does not include medical necessity determinations generally or other forms of medical management techniques

Disclosure Notice

Plans and issuers are required to provide a notice, in connection with a request for cost-sharing liability, informing participants, beneficiaries, and enrollees of the following:

- OON providers may balance bill participants, beneficiaries, or enrollees, and the estimated cost-sharing liability does not account for these potential additional amounts
- Actual charges for the covered items or services may be different from the estimate, depending on the actual items and services received at the point of care
- 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
- Any additional information the plan or issuer would like to include

The departments released a proposed model notice for comment

Internet-Based, Self-Service Tool

- Require *real-time* cost-sharing information to be made available through a free internet-based, self-service tool which allows participants, beneficiaries, or enrollees to search for cost-sharing information for a covered item or service by inputting:
 - A billing code (e.g., CPT Code) or a descriptive term (e.g., rapid flu test), at option of user; *and*
 - Other factors such as geographic location of the service, facility name, or quantity or dosage
- Tool would need to be able to provide accurate information at the time of the search request

Special Rule for Unnecessary Duplication

- For insured group health plans, the plan would satisfy the requirements of the proposed rules if the issuer offering the coverage is required to provide the information *pursuant to a written agreement* between the plan and issuer
 - If the issuer fails to provide the required disclosures, then the issuer would violate the disclosure requirements

Machine Readable Files

Public Disclosure of Negotiated Rates and Allowed Amounts

- The proposed rules require plans and issuers to make available on a public internet website two machine-readable files that include information regarding:
 - Negotiated rates with in-network providers
 - Historical allowed amounts for covered items or services furnished by particular OON providers

Public Disclosure of Negotiated Rates and Allowed Amounts (cont.)

- This information must be updated on a monthly basis
- The machine-readable files 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

Negotiated Rate File

- The Negotiated Rate file must include:
 - The name and identifier for each plan option or coverage offered by the plan or issuer (i.e., “EIN” or “HIOS” identifier, as applicable)
 - Billing code used by the plan or issuer to identify covered items or services for purposes of claims adjudication and payment, and a plain language description for each billing code (associated with each negotiated rate)
 - Negotiated rates in dollar amounts, under a plan or coverage, with respect to each item or service furnished by in-network providers, and associated with the provider’s NPI for each in-network provider
 - Last date of the contract term for each provider-specific negotiated rate that applies to each item or service

Allowed Amount File

The Allowed Amount file must include:

- The name and identifier for each plan option or coverage offered by the plan or issuer (i.e., “EIN” or “HIOS” identifier, as applicable)
- Billing code used by the plan or issuer to identify covered items or services for purposes of claims adjudication and payment, and a plain language description for each billing code (associated with each OON allowed amount)
- Unique, historical OON allowed amounts, in dollar amounts, for covered items and services by OON providers during the 90-day time period that begins 180 days prior to the publication date of the file, and associated with the provider’s NPI for each provider
 - Plans and issuers required to omit OON allowed amount data in relation to a particular provider and a particular item or service when compliance would require reporting in connection with fewer than 10 different claims for payment

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Special Rule for Unnecessary Duplication (cont.)

- A plan or issuer may satisfy the public disclosure requirement by entering into a written agreement with another party (such as a TPA or health care claims clearinghouse) to make public the required information, however, the plan or issuer would still be liable
 - Under these circumstances, the proposed regulations would allow issuers, service providers, or other parties with which the plan or issuer has contracted to aggregate out-of-network allowed amounts for more than one plan or insurance policy or contract

Applicability

- The proposed rules, if finalized, would apply for plan or policy years beginning on or after one year after the effective date of the final rule
 - The departments request feedback on the proposed applicability date, and the timing necessary to develop the cost-estimation tools and machine-readable files
- The proposed rules would not apply to grandfathered health plans, health reimbursement arrangements or other account-based group health plans, excepted benefits, and short-term, limited duration insurance

Good Faith Safe Harbor

- A plan or issuer will not fail to comply with the disclosure requirements if the plan or issuer, acting in good faith and with reasonable diligence, makes an error or omission in its disclosures, or the plan or issuer's internet website is temporarily inaccessible and the plan or issuer corrects any error or omission or makes the required information available as soon as practicable
- A plan or issuer won't fail to comply with the disclosure requirements because it relied in good faith on information from another entity, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate

Requests for Information

Requests for Information

- Disclosure of pricing information through a standards-based API
 - The departments are considering whether to require, through future rulemaking, that plans and issuers make available discrete data elements through a standards-based application programming interface (“API”)
- Provider quality measurement and reporting in the private health insurance market
 - The departments are interested in how public and private sector quality measures might be used to compliment cost-sharing information for plans and issuers in the private health insurance market

Questions?

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