Complying with the Final Rules on Transparency in Group Health Plan Coverage

Presented by:

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Agenda

- Purpose and possible impact of regulatory freeze
- Coverage (and which plans are not covered)
- Effective Dates
- Describe the disclosure of cost information requirement and how plans may estimate cost-sharing liability
- Discuss the public disclosure of negotiated rates and historical allowed amounts requirement
- Describe the good faith safe harbor for plan sponsors
- Next Steps

Final Rules on Coverage Transparency

- Background and Purpose

Applicability

- Non-Grandfathered Group Health Plans/Health Plans under IRC, ERISA and PHSA
  - No church or government plan exception
  - Fully-insured and self-insured covered

Applicability

The following types of plans and coverage are not subject to the final rules:

- grandfathered plans;
- excepted benefits (e.g. most EAPs, dental, vision);
- health care sharing ministries;
- short-term, limited-duration insurance; or
- account-based health plans (FSAs, HSAs, and HRAs, including ICHRAs and QSEHRAs)

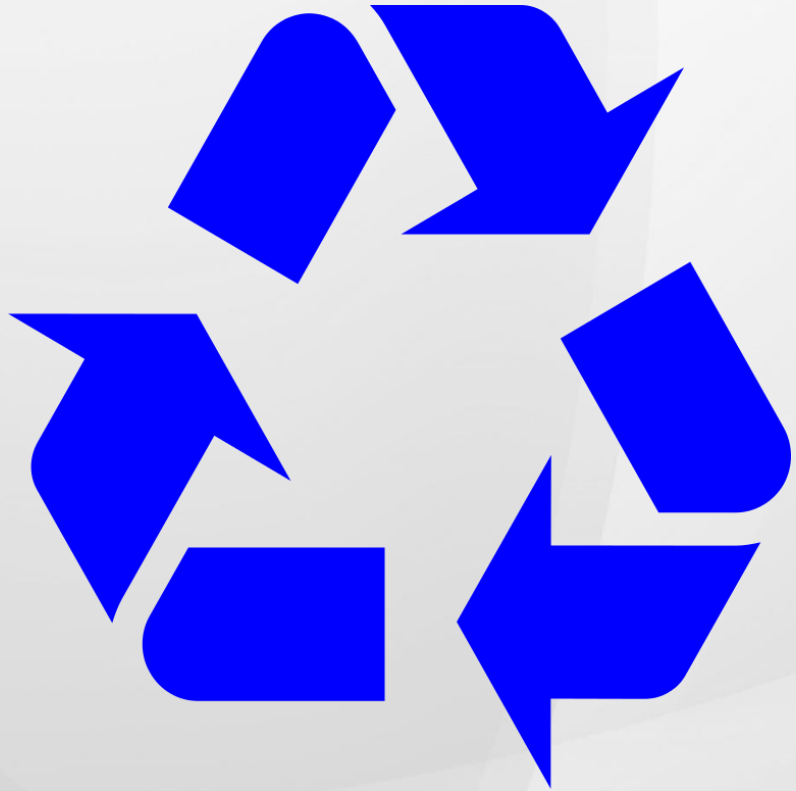
Current Effective Dates

- Public Disclosure of Negotiated Rates and Historical Allowed Amounts: January 1, 2022
- Disclosure of Cost Information – January 1, 2023 and January 1, 2024
- Medical Loss Ratio Calculation: 2020 MLR Reporting Year (paid in 2021)
    - *These effective dates could change based on executive order or legal challenges*

Disclosure of Cost Information

Disclosure of Cost Information

Explanation of Benefits Recycled?



Required Disclosures

1. **Estimated cost-sharing liability** – The amount a health coverage recipient is responsible for paying for a covered item or service
    - deductibles
    - coinsurance requirements
    - copayments.

- Plans and issuers should provide one overall cost-sharing liability estimate for a bundled payment arrangement if that is the only cost sharing
- Preventive vs. non-preventive
    - plan or issuer must display the non-preventive cost sharing liability along with a statement may not be subject to cost-sharing if it is billed as a preventive service.

Required Disclosures

2. Accumulated amounts

The amount of financial responsibility that a health coverage recipient has incurred at the time the request for cost-sharing information is made (deductible and/or an OOP)

- Individual vs. Family
- Must include amounts accrued toward non-dollar limits such as days, units, or visits.

Required Disclosures

3. In-network rates – The amount a plan or issuer has contractually agreed to pay for a covered item or service, whether directly or indirectly through a TPA or pharmacy benefit manager (PBM), to an in-network provider, including an in-network pharmacy or other prescription drug dispenser, for covered items or services.

- Underlying fee schedule rate if different from the negotiated rate.
- N/A for RBP or similar plans with no negotiated rates or underlying fee schedule rates (for example plans or issues using alternative reimbursement models, such as a capitated or bundled payment arrangements)
- For prescription drugs, plans and issuers must disclose: (1) an individual's out-of-pocket cost liability for prescription drugs, and (2) the negotiated rate of the drug.

Required Disclosures

4. **Out-of-network allowed amount** – The maximum amount (or method to calculate) what the plan will pay an out-of-network provider – must include cost-sharing liability for the health coverage recipient.

Required Disclosures

5. **Items and services content list** – A list of those covered items and services for which cost-sharing information is disclosed.

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.

Required Disclosures

7. **Disclosure notice** – 5 specific disclaimers:
   - Balance billing may apply
   - Actual charges may be different
   - Estimate is not a guarantee of coverage for items and services
   - Whether plan counts copayment assistance/third-party payments in the calculation of the deductible and out-of-pocket maximum
   - Preventive care may or may not be subject to cost-sharing depending on how billed by provider

Permitted to include additional information if not in conflict with the information required to be provided in the notice

Required Methods for Disclosure

The cost-sharing information described above must be disclosed *without a fee* using two methods:

1) an internet-based self-service tool, and

2) in paper form if requested.

Required Methods for Disclosure

Disclosure via Internet-Based Self-Service Tool - Requirements

- Allow users to search for real-time accurate cost-sharing information for covered items and services provided by a specific in-network provider, or by all in-network providers.
- Allow users to search for the out-of-network allowed amount for a covered item or service provided by out-of-network providers.
- Permit users to refine and reorder search results based on geographic proximity of in-network providers
- Permit 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.
- Produce the relevant cost-sharing information for the covered item or service for each tier for multi-tiered network.
- Allow users to input variables and receive estimates if cost-sharing is based on factors other than provider (e.g. a specific facility or Rx dosage)

Required Methods for Disclosure

Disclosure via Paper Requirements

- Paper copies of the cost-sharing information under the internet tool must be available upon request.
- Mailed to the requesting health coverage recipient within 2 business days
- If request returns more than one result, the participant can request that it be refined and reordered by geographic proximity and cost-sharing liability estimates
- May limit to 20 providers per request.
- With agreement of requesting individual, this “paper” disclosure may be satisfied by communication via phone or e-mail within same time frame

Effective Dates for Coverage Disclosures

- January 1, 2023
  - Estimated cost-sharing information in *plain language* for 500 covered items or services listed in Table 1 of the final rule (includes prescription drugs and durable medical equipment)
- January 1, 2024
  - Estimated cost-sharing information in *plain language* for all covered items or services regardless of whether listed in Table 1

Responsibility for Disclosure

- Penalty structure same as ACA ($100 per person, per day, per violation) and responsibility of GHP/employer
- Fully-Insured GHPs – Sponsor may contract with issuer and shift responsibility for penalty under final rule (“fully-insured safe harbor”)
- Third-Party Contracts - Sponsor of self-insured GHP or an issuer may contract with third party (e.g. PBM for Rx), but cannot shift responsibility under final rule
  - Contract terms are key to protecting sponsor

Good Faith Compliance Safe Harbor

- A plan or issuer will not fail to comply with the final 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 final 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 final 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.

Final Rules on Coverage Transparency

Medical Loss Ratio Rebates

Shared Savings and the MLR Rule

- Under the final rules, HHS allows 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.

Public Disclosure of Negotiated Rates

Public Disclosure of Negotiated Rates

- Big Picture: beginning 1/1/2022 – GHPs/Issuers must publish, *for public viewing and access*, machine-readable files showing plan design information including negotiated rates and historical allowed amounts for out-of-network providers

- Penalty structure and safe harbors are the same for the public disclosure rule (ACA - $100 per day, per person, per violation)

  - Fully-insured plan sponsors can contract away liability to issuer, but not self-insured plan sponsors

  - However, “Good Faith Compliance Safe Harbor” also applies

Requirements for Public Disclosure of Negotiated Rates

Disclosure Requirements:

- Disclosure must be available on an internet website to the public without requiring access credentials
- Must include three machine-readable files showing:
  - an in-network rate file
  - an out-of-network allowed amount file
  - a prescription drug machine-readable file.
- "Machine readable" means non-proprietary open format 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 (e.g. no PDF files due to its proprietary nature).

Requirements for Public Disclosure of Negotiated Rates

The requirements of each file are as follows.

1. The **In-Network Machine Readable File must** include:
   a) For each coverage option offered by a plan or insurer, the name and 14-digit HIOS identifier (if one is available), the 5-digit HIOS identifier (if the 14-digit is not available), and the EIN if no HIOS identifier is available.
   b) A billing code (the code used by the plan or insurer to identify items or services for purposes of billing, such as a CPT Code, HCPCS code, DRG, or NDC) and a plain language description for each billing code for each covered item or service.
   c) All applicable rates, which may include one or more of: negotiated rates, underlying fee schedule rates (the rate from an in-network provider to determine cost-sharing liability), or derived amounts (the price assigned to an item or service for purpose of internal accounting, reconciliation with providers or submission of data). For items or services in a bundled payment, the applicable rate is to be a dollar amount for each covered item or service and other specified information.

Requirements for Public Disclosure of Negotiated Rates

2. The **Allowed Amount Machine Readable File** must include:

a) For each coverage option offered by a plan or insurer, the name and 14-digit HIOS identifier (if one is available), the 5-digit HIOS identifier (if the 14-digit is not available), and the EIN if no HIOS identifier is available.

b) A billing code (the code used by the plan or insurer to identify items or services for purposes of billing, such as a CPT Code, HCPCS code, DRG or NDC) and a plain language description for each billing code for each covered item or service.

Requirements for Public Disclosure of Negotiated Rates

c) Unique out-of-network allowed amounts and billed charges with respect to covered items or services of out-of-network providers during the 90-day period that begins 180 days prior to the publication date of the file (but the plan or insurer must omit such data in relation to a particular item or service and provider if out-of-network allowed amounts in connection with fewer than 20 different claims under a single plan or coverage). The unique out-of-network allowed amount must be stated as a dollar amount with respect to the covered item or service furnished by an out-of-network provider, and associated with the NPI, TIN or Plan of Service Code for each out-of-network provider.

d) Historical data showing allowed amounts and billed charges (i.e., balance bills) for covered items and services, including prescription drugs, furnished by out-of-network providers for which the plan or issuer has adjudicated the claims. Plans and issuers may satisfy the public disclosure requirements for the Allowed Amount File by making available out-of-network allowed amount data that has been aggregated to include information from more than one plan or policy. However, data for each plan or coverage included in an aggregated Allowed Amount File must independently meet the minimum claims threshold for each item or service and for each plan or coverage included in the aggregated Allowed Amount File.

Requirements for Public Disclosure of Negotiated Rates

3. The **Prescription Drug Machine Readable File** must include:
    a) For each coverage option offered by a plan or insurer, the name and 14-digit HIOS identifier (if one is available), the 5-digit HIOS identifier (if the 14-digit is not available), and the EIN if no HIOS identifier is available.
    b) A billing code (the code used by the plan or insurer to identify items or services for purposes of billing, such as a CPT Code, HCPCS code, DRG or NDC) and a plain language description for each billing code for each covered item or service.
    c) Negotiated rates and historical net prices (which takes into account rebates, discounts, dispensing fees, and other price concessions) connected to in-network prescription drugs paid for on a fee-for-service basis. If the prescription drugs are part of a bundled payment arrangement, they must be disclosed in the In-network File. Plans and issuers are not required to provide historical net price data in the Prescription Drug File in relation to a particular pharmacy or other prescription drug dispenser with fewer than 20 different claims for payment.

Good Faith Safe Harbor Reminder!

- A plan or issuer will not fail to comply with the final 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 final 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 final 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.

Final Rules on Coverage Transparency

Planning and Next Steps

Next Steps

- Make sure you understand what is required by the final rule and when – this is a good start!
- Inventory GHPs to determine which are subject to the rule
- Determine which of your GHPs, if any, the compliance obligation may be shifted to insurer
- For Self-Insured GHPs, determine which obligations you may want to assume in house and which to contract out to a third party
- Evaluate current providers and if they will be able to comply upon request
- Carefully negotiate contract renewals and any third-party compliance contracts
  - Clearly outline responsibilities of issuer/third party
  - Establish compliance plan of action to support good faith defense
- Plan for increased budgeting to comply
- Implement early! Anticipate hiccups and compliance glitches (remember those first years of ACA reporting??)

Final Questions

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HRCI –

SHRM –

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Thank You

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