Final Rules on Coverage Transparency

Part 1

15-Minute Read

On October 29, 2020, the Internal Revenue Service (IRS), Department of Labor (DOL), and the Department of Health and Human Services (HHS) (collectively, Departments), released final rules on coverage transparency, in order to provide health coverage recipients with an estimate of their potential cost-sharing liability for health related services prior to the receipt of care. The final rules require group health plans and insurance issuers in the individual and group markets to disclose cost-sharing information and negotiated rates in electronic or paper form. The information required to be disclosed under the final 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. It is important that plan sponsors and issuers agree, in writing, on which party will be responsible for satisfying the disclosure obligation. The final rules also allow issuers to reward plan enrollees with "shared savings payments," without running afoul of medical loss ratio (MLR) requirements. Issuers are permitted to provide employees who use lower-price providers with a percentage of the savings relative to a benchmark.

HHS has released a fact sheet and a press release regarding the final rules.

Applicability

The following types of plans and coverage aren't subject to the final rules: grandfathered health plans; excepted benefits; health care sharing ministries; short-term, limited-duration insurance; or other account-based health plans (FSAs, HSAs, and HRAs, including ICHRAs and QSEHRAs) that simply make certain dollar amounts available.

Effective Dates

- Public Disclosure of Negotiated Rates and Historical Allowed Amounts: January 1, 2022 (see upcoming Part 2 of this Advisor for more information)
- Disclosure of Cost Information: January 1, 2023, through January 1, 2024
- Medical Loss Ratio Calculation: 2020 MLR Reporting Year

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

Coverage Transparency Final Rules

Effective January 1, 2023, group health plans and health insurance issuers in the individual and group markets must disclose estimated cost-sharing information in plain language for covered items or services (500 items and services which are identified in Table 1 beginning on pg. 93 of the final rule) including prescription drugs and durable medical equipment. Plans and issuers will be required to disclose pricing information with respect to all items and services for plan years beginning on or after January 1, 2024, regardless of whether the item or service is listed in Table 1.

Required Disclosures

1. **Estimated cost-sharing liability** – The amount a health coverage recipient is responsible for paying for a covered item or service. The disclosure must include all applicable forms of cost sharing, including deductibles, coinsurance requirements, and copayments. Plans and issuers should provide one overall cost-sharing liability estimate for a bundled payment arrangement if that is the only cost sharing for which the participant, beneficiary, or enrollee would be liable. If an item or service is a recommended preventive service, and the plan or issuer cannot determine whether the request is for preventive or non-preventive purposes, the 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.

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, with respect to a deductible and/or an out-of-pocket limit. For individuals enrolled in other than self-only coverage, the accumulated amounts include the financial responsibility toward the individual's deductible and/or out-of-pocket limit and the other than self-only coverage deductible and/or out-of-pocket limit. Accumulated amounts also include amounts accrued toward limits such as days, units, or visits.

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 third party administrator (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. Plans and issuers must disclose the underlying fee schedule rate used to determine cost-sharing liability only where that rate is different from the negotiated rate. If the plan or issuer does not have negotiated rates or underlying fee schedule rates (for example plans or issues using alternative reimbursement models, such as a capitated or bundled payment arrangements), this third content element does not apply. 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.

4. **Out-of-network allowed amount** – The maximum amount or any other calculation that provides a more accurate estimate of the amount, such as the usual, customary, and reasonable (UCR) amount, a plan will pay for the requested 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 for the health coverage recipient.

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 health coverage recipient 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, including concurrent review, prior authorization, step-therapy, and fail-first protocols, that must be satisfied before a plan or issuer will cover the item or service. This is the exhaustive list of prerequisites that plans and issuers are required to provide notice.

7. **Disclosure notice** – The disclosure notice must include five disclaimers:

    1) Out-of-network providers may bill health coverage recipients 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 (i.e., balance billing). The estimates do not account for those potential additional amounts. This disclosure is only required if balance billing is permitted under state law.

    2) Actual charges for the 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.

    4) A statement disclosing whether the plan counts copayment assistance and other third-party payments in the calculation of the deductible and out-of-pocket maximum.

    5) For items and services that are recommended preventive services, a statement that an in-network item or service may not be subject to cost-sharing if it is billed as a preventive service if the group health plan or health insurance issuer cannot determine whether the request is for a preventive or non-preventive item or service.

    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.

Required Methods for Disclosure

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

Disclosure via internet-based self-service tool

The internet-based self-service tool must 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. 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. Users must be permitted to refine and reorder search results based on geographic proximity of in-network providers, and 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 are encouraged to rely upon federal plain language guidelines and ERISA disclosure requirements for presentation, and general industry standards for guidance on developing internet-based self-service tools. The tool must be accessible via website.

Disclosure via paper

Plans and issuers must make paper copies of the cost-sharing information described above, available upon request.

The information must be mailed to the requesting health coverage recipient no later than two business days after the request is received. To the extent the information the individual requests returns more than one result, the individual would also be permitted to request that the plan or issuer refine and reorder the information disclosed by geographic proximity and the amount of the cost-sharing liability estimates. A plan or issuer may limit any results for a paper request to 20 providers per request. Information may also be disclosed by a method other than paper (for example, by phone or e-mail), provided the requester agrees that disclosure through such means is sufficient to satisfy the request and the request is fulfilled at least as rapidly as required for the paper method.

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 final rules. Plans and issuers may fulfill pricing disclosure requirements for prescription drugs through a third-party tool, such as a PBM tool, however, if the tool fails to provide information in compliance with the final rules, the plan or issuer may be held responsible for the violation.

Good Faith 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.

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. Issuers are 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.

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