Final Rules on Coverage Transparency
Part 2
Public Disclosure of Negotiated Rates

10-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, the 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. See our Part 1 Advisor.

The final rules require group health plans and insurance issuers to disclose negotiated rates and historical allowed amounts to the public through machine-readable files. Insured plans may satisfy the disclosure obligation by contracting with the issuer to provide the information required under the final rules, with such delegation of responsibility absolving the plan from liability for the issuer's noncompliance with the final rules, provided the issuer is independently subject to the final rules. However, if a plan or issuer enters into an agreement with other third parties (such as a TPA or healthcare clearinghouse) to provide the public disclosures and the third party fails to provide full or timely information, the plan or issuer will have violated the final rules' public disclosure requirements.

HHS 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
- Disclosure of Cost Information: January 1, 2023, through January 1, 2024 (see Part 1 Advisor)
- Medical Loss Ratio Calculation: 2020 MLR Reporting Year (see Part 1 Advisor)

Requirements for Public Disclosure of Negotiated Rates

The rule also contains requirements for public disclosure of certain information on an internet website, without requiring access credentials, in three machine-readable files: 1) an in-network rate file, 2) an out-of-network allowed amount file, and 3) a prescription drug machine-readable file. Under the rule, "machine readable" is defined as a 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. A PDF file, for example, would not meet this definition due to its proprietary nature.

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.

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.

    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.

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.

See **Appendix A** for an Allowed Amount File example and Prescription Drug File examples from the final rules.

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.

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Appendix A

Allowed Amount File Example

For example, an out-of-network provider (under a single NPI, TIN, and Place of Service Code) submits 25 claims (or any other number of claims to meet the 20 unique claim threshold requirement discussed in more detail later in this preamble) to a plan or issuer for the service Y. The 25 claims have three different billed charges ($100, $150 and $200) and two different allowed amounts ($50 and $150) for item Y.

The plan or issuer should have one entry that represents each unique combination of billed charges and allowed amounts submitted by the out-of-network provider. Therefore, in this example, the Departments would expect the plan or issuer to represent in the Allowed Amounts File no fewer than three unique entries, and no more than six unique entries for item Y from this out-of-network provider. For example:

- Entry A has a billed charge of $100 and an associated allowed amount of $50
- Entry B has a billed charge of $150 and an associated allowed amount of $50
- Entry C has a billed charge of $200 and an associated allowed amount of $50
- Entry D has a billed charge of $100 and an associated allowed amount of $150
- Entry E has a billed charge of $150 and an associate allowed amount of $150
- Entry F has a billed charge of $200 and an associated allowed amount of $150

The Departments do not expect to see 25 different entries, unless they represented 25 distinct combinations of billed charges and associated allowed amounts from the out-out network provider for Item Y.

Prescription Drug File Example

For example, if a rebate amount of $20,000 is received during the 3-month file reference period in connection with $100,000 in sales on two drugs during the same period, the rebate is allocated as a 20 percent discount to the prices of those two drugs. Sales for Drug A totaled $60,000 and sales for Drug B totaled $40,000. A rebate of $12,000 ($60,000 multiple by 20 percent) is allocated to Drug A, resulting in a historical net price populated in the Prescription Drug File of $48,000. Similarly, a rebate of $8,000 is allocated to Drug B, resulting in a historical net price populated in the Prescription drug file of $32,000.

Prescription Drug File Example (when historical net price is not known at the time of publication)

To reasonably allocate any particular non-product specific or product-specific rebate, discount, chargeback, fee, or other additional price concession where the total amounts are not fully known at the time of file publication, plans and issuers must make a good faith, reasonable estimate of the price concession using an historical adjustment amount. To make this estimate, plans and issuers shall determine the average value of price concessions for the relevant product over a time period prior to the current reporting period and of equal duration to the current reporting period and use that amount to apply an estimated adjustment amount in the current reporting period. For example, Plan X has $100,000 in total sales for 20,000 units—averaging $5 per unit—of Drug A during the current reporting period, which is January 1, 2020, through March 31, 2020. However, Plan X will not know the total amount of product-

specific rebate to expect for sales of Drug A for at least another six months. To address this timing issue, Plan X can apply a reasonable estimate to allocate an adjustment to the current reporting period. For instance, Plan X can look back to the total rebates received for the product during a comparable time period. In this example, Plan X reviews its historical data and determines the rebates received for Drug A, from the period between January 1, 2019, and March 31, 2019, totaled $10,000 for sales of 30,000 units totaling $160,000. The average price per unit was $5.33 and the average discount per unit was $0.33 resulting in an average final net price of $5 for Drug A. Plan X then applies this historical rebate percentage to the current reporting period for Drug A. Plan X subtracts $6,250 ($100,000 total sales for the current reporting period multiplied by the estimated 6.25 percent historical rebate percentage) from the $100,000 total sales for a total net price of $93,750 and an average net price for Drug A, rounded to the nearest hundredth, of $4.69. Plan X reports in the Prescription Drug File an average historical net price for Drug A of $4.69 for the current reporting period.