AMERICAN BENEFITS COUNCIL

Benefits Briefing Webinar

A Closer Look at Price Transparency Implications

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Today's Speakers

Moderators:

Ilyse Schuman
Senior Vice President, Health Policy
American Benefits Council

Guest Speakers:

Matthew Lynch
Director, State Marketplace and Insurance Programs Group
U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO)

Deborah Bryant
Senior Advisor, Consumer Support Group
CCIIO

Matthew Litton
Deputy Director, Office of Health Plans Standards and Compliance Assistance
U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA)

Lisa Campbell
Principal
Groom Law Group

Seth Perretta
Principal
Groom Law Group

Transparency in Coverage Final Rule

Lisa M. Campbell

Seth Perretta

GROOM LAW GROUP

Agenda

- Background
- Applicability and timing
- Internet-based, self-service cost-sharing tool
- Machine-readable files - public disclosure pricing data
- Special rule to prevent unnecessary duplication, privacy and security, enforcement, and good faith safe harbors
- Implications for plan sponsors

Background

Rulemaking

- **Proposed regulations** issued November 27, 2019, in response to executive order No. 13877, entitled "Improving Price and Quality Transparency in American Healthcare to Put Patients First"
- **Final regulations** published November 12, 2020, implementing section 2715A of the Public Health Service Act ("PHS Act") and section 1311(e)(3) of the Patient Protection and Affordable Care Act ("ACA")

Stated Rationale

The departments are of the view that "[b]y requiring the dissemination of price and benefit information directly to consumers and to the public, the transparency in coverage requirements will provide the following consumer benefits:

- Enables consumers to evaluate health care options and to make cost-conscious decisions;
- Strengthens the support consumers receive from stakeholders that help protect and engage consumers;
- Reduces potential surprises in relation to individual consumers' out-of-pocket costs for health care services;
- Creates a competitive dynamic that may narrow price dispersion for the same items and services in the same health care markets; and
- Puts downward pressure on prices which, in turn, potentially lowers overall health care costs."

85 Fed. Reg. 72160

Applicability

- **Final rules apply to:**
  - Self-funded group health plans (non-grandfathered);
  - Group and individual health insurance coverage (non-grandfathered); and
  - "grandmothered" plans
- Final rules do **not** apply to grandfathered health plans; HRAs or other account-based group health plans; excepted benefits; short-term, limited duration insurance; and expatriate health plans

Components (and Timing)

1. **Internet-Based, Self-Service Tool**
   - Applies to: 500 items and services identified in the final regulations, beginning with plan or policy years on or after January 1, 2023; and
   - Effective: For all items and services, beginning with plan or policy years on or after January 1, 2024

2. **Three Machine-Readable Files, Publicly Posted**
   - Applies to: In-network rates, OON allowed amounts and billed charges, and prescription drug negotiated rates and historical net prices
   - Effective: Beginning with plan or policy years on or after January 1, 2022

Internet-Based, Self-Service Cost-Sharing Tool

Cost-Sharing Tool - Data Elements

Plans and issuers must 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
- **In-network rate** (reflected as a dollar amount) for an in-network provider for the covered item or service (includes negotiated rate and underlying fee schedule)
- **Out-of-network allowed amount** for the covered item or service
- If a bundled payment arrangement, a list of the items or services
- Any **prerequisite** for the covered item or service

Cost-Sharing Tool - Required Notice

Notice is required in connection with a request for cost-sharing liability, that includes 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 (*only required if balance billing permitted under state law*)
- 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 benefits will be provided for that item or service
- Whether plan counts copay assistance or other 3rd party payments toward deductible and OOP limit
- An in-network item or service may not be subject to cost-sharing if it is billed as a preventive service
- Any additional information the plan or issuer determines is appropriate

Cost-Sharing Tool - Additional

- Information **must be in plain language, without subscription or fee**
- **Requires search functionality 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;
  - Name of in-network provider; and
  - Other factors such as location of the service, facility name, or dosage
- **Must refine and reorder search based on geography of provider and amount of cost-sharing liability**
- **Requested information must be provided:** in paper form, free upon request and mailed no later than 2 business days after request is received; may limit number of providers for cost share information to 20 providers per request; may provide information by phone or email, if that was the manner requested

Machine-Readable Files

Machine-Readable Files – Public Disclosure Pricing Data

- **The final rules require plans and issuers to make available on a public internet website three machine-readable files that include information:**
  - **In-network rate file**, may include negotiated rates, underlying fee schedule rates, or derived amounts
  - **OON allowed amount file**, includes historical allowed amounts and billed charged for covered items or services furnished by OON providers for 90-day time period beginning 180 days prior to publication (omit if fewer than 20 claims under single plan or coverage)
  - **Prescription drug file**, includes negotiated rates, and historical net prices for 90-day time period beginning 180 days prior to publication inclusive of rebates (omit if fewer than 20 claims under single plan or coverage)

Machine-Readable Files – Public Disclosure Pricing Data

- This information (i.e., slide 13 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

Applies to Both Components

Special Rule to Prevent Unnecessary Duplication

- For insured group health plans, the plan would satisfy the requirements 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, the issuer violates the disclosure requirements
- A plan or issuer may satisfy the requirements by entering into an agreement with another party
  - If the third-party fails to provide the required disclosures, the plan or issuer violates the disclosure requirements

Special Rule to Prevent Unnecessary Duplication (cont.)

- For the machine-readable files, if the plan or issuer contracts with an issuer, service provider, or other party to provide the OON allowed amount data, the OON allowed amount data may be aggregated for more than one plan or insurance policy or contract

Privacy and Security

- Nothing in the final regulations is intended to alter or otherwise affect plans' and issuers', and other entities' data privacy and security responsibilities under HIPAA rules or other applicable state or federal laws

Enforcement

- **Same enforcement framework as for the ACA market reform requirements**
  - I.e., DOL has enforcement authority for group health plans subject to ERISA, Treasury has jurisdiction over certain church plans, and HHS has jurisdiction over non-Federal governmental plans and over health insurance issuers where HHS determines that a state is not substantially enforcing the requirements
- **Self-funded plans - failure to comply would subject plan to monetary penalties under IRC section 4980D**
  - I.e., $100/day per violation per affected participant

Good Faith Safe Harbors

- **A plan or issuer will not fail to comply solely because:**
  - Despite acting in good faith and with reasonable diligence, it makes an ***error or omission in a disclosure***, provided the plan or issuer corrects the information as soon as practicable
  - Despite acting in good faith and with reasonable diligence, its *internet* ***website is temporarily inaccessible***, provided the plan or issuer make the information available as soon as practicable
  - ***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

Considerations for Plan Sponsors

- **When contracting with service providers**
  - May need to amend contracts
  - Continued liability if contract with TPA
- **Consideration of public information** on provider reimbursement for service provider selection
- **Limitations may exist when seeking to use public pricing data to develop innovative plan designs** (e.g., steer patients towards higher-value, lower-cost health care providers)
- **New Administration and potential for additional guidance**

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