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ADVISORY

Federal agencies propose new sweeping

transparency rules for health plans

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The Departments of Labor, Health and Human Services, and Treasury published new proposed rules that, if finalized, will require most individual and group health plans to provide additional information to plan participants and the public. This proposed rule is a response to the president's June 2019 executive order on improving price and quality transparency and is based on transparency provisions of the Affordable Care Act (ACA).

The proposal has two key elements: (1) Upon request from a plan participant or beneficiary, covered health plans are required to disclose detailed estimates of cost-sharing for specific items or services; and (2) it requires covered health plans to publicly disclose negotiated rates for in-network providers and historical allowed amounts for out-of-network providers.

The overall purpose of the proposal is to support a market-driven health care system by giving consumers the information they need to make informed decisions about their health care and health care purchases.

This article provides a high-level overview of key provisions in the proposed rule.

Covered plans

The proposed rule applies to most health plans, including individual market plans and fully insured and self-funded large and small group plans, with a few important exceptions.

The proposed rule does NOT apply to:

- Excepted benefit plans such as dental, vision, hospital indemnity and other fixed indemnity, specified disease and critical illness policies.
- Grandfathered plans.
- Short-term limited duration insurance.
- Health reimbursement arrangements (HRAs). The rule excludes HRAs because they only make a specific dollar amount available, so cost-sharing concepts do not apply.

Although the proposed rule does not apply to grandfathered plans, it does apply to so-called “grandmothered” or transitional plans. Grandmothered plans are certain nongrandfathered individual and small group plans that federal and state regulators allow to continue in force for a transition period — even though they don’t comply with certain ACA requirements. The current grandmothered plan guidance applies for policy years beginning on or before Oct. 1, 2020, provided that all coverage comes into full compliance by Jan. 1, 2021. More information on current rules for grandmothered plans may be found here.

Cost-sharing disclosure — required information

The proposed rule requires plans to disclose seven specific points of information regarding cost-sharing for an item or service:

Plan administrators will have flexibility to use either the existing safe harbor or the new safe harbor for retirement plan notices. That means they can use the current safe harbor for some participants and notices and the new safe harbor for others.

1	**Estimated cost-sharing liability.** This is the plan participant's share of the cost of the item or service under the plan. This includes any deductible, co-payments and coinsurance. It doesn't include balance billed amounts from out-of-network providers or premiums.
2	**Accumulated amounts.** This includes financial amounts with respect to a plan deductible or out-of-pocket maximum the participant has already incurred at the time the request for cost-sharing information is made. This also includes amounts accrued toward any treatment limits (e.g., limits on the number of physical therapy visits per year or per event).
3	**Negotiated rate.** This is the amount the plan pays an in-network provider for the item or service and also used to determine the amount of cost-sharing.
4	**Allowed out-of-network amount.** The maximum amount a plan will pay an out-of-network provider for the item or service. This does not include any amount that the out-of-network provider may separately bill the participant (i.e., balance bill).
5	**Items and services content list.** When cost-sharing information relates to a bundled payment, plans need to provide a list of covered items and services included in the bundle and cost-sharing for the bundle as a whole.
6	**Notice of prerequisites to coverage.** When a participant requests cost-sharing information, health plans must also provide information about the conditions that need to be satisfied before the item or service is covered by the plan. Prerequisites include concurrent review, prior authorization, step-therapy and fail-first protocols.
7	**Disclosure notice.** Plans must provide a notice, in plain language, that includes the following statements: Out-of-network providers may balance bill patients and the estimates of cost-sharing do not include balance billing amounts from providers; actual charges for the items or services may vary from the cost-sharing estimate depending on the actual items and services received; and the cost-sharing estimate isn't a guarantee that coverage will be provided for the items and services. The agencies have provided a draft model notice for plans to use. Plans aren't required to use the model notice and may develop their own notice as long as it meets the requirements in the proposed rule.

Cost-sharing disclosure — required formats

Plans must provide required cost-sharing information in two ways: (1) through an internet-based self-service tool; and (2) in paper form by mail upon request. The self-service tool must provide real-time responses, be searchable by billing code or descriptive term and interact with participant input to deliver meaningful cost-sharing information depending on any network tiering, network status of providers — including information for a particular provider — and other factors. Paper forms must include all required information and must be mailed no later than two days after the request for the information.

Plans may provide participants the option to request disclosure in other formats, such as by phone or email.

Public disclosure of negotiated in-network rates and allowed out-of-network amounts

The proposed rule requires covered health plans to publicly disclose in-network negotiated rates and data regarding historical allowed amounts for out-of-network covered items or services. Plans must provide this information in two machine-readable files, one for the in-network rates (negotiated rate file) and another for the historical out-of-network allowed amounts (allowed amounts file).

The negotiated rate file must include information such as the dollar amount of the negotiated rate for each in-network item or service, associated with the provider's national provider identifier (NPI), separated by network tier, if applicable, and the relevant code for the service. The agencies provided a list of the data elements required for the negotiated rate file.

The allowed amount file must include information such as each unique out-of-network allowed amount for covered items or services provided by each out-of-network provider during the 90-day period that begins 180 days before the allowed amount file's publication. Also, health plans must disclose the aggregate of the actual amount the health plan paid to the out-of-network provider and the consumer's share of the cost. The agencies provided a list of data elements required for the allowed amount file.

As proposed, plans must update these files monthly. More frequent updates are under consideration for inclusion in a final rule, such as within 10 calendar days of the effective date of new rates.

Compliance through third parties

A fully insured group health plan satisfies its obligations under the rule if the plan, in a written contract, requires the insurer to provide cost-sharing information and public disclosure in accordance to the rule. If the insurer then fails to fully satisfy the disclosure rules (e.g., doesn't provide all required cost-sharing information), the insurer, not the plan, is in violation.

Group health plans and insurers may also use third parties (such as a third-party administrator or health care claims clearinghouse) to satisfy the public disclosure requirements through a written agreement. However, if the third party fails to meet the requirements, then the plan or issuer is in violation.

Conclusion

The proposed disclosure rules, if finalized, will impose significant new requirements on covered health plans. The requirement for public disclosure of rate information is likely to be particularly controversial. Nevertheless, given that this rule was issued in response to the president's executive order, we expect it to be finalized, possibly with some changes, in the first half of 2020.

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