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LEGAL ADVICE FOR HEALTH PLANS

HEALTH LAW ALERT
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Final Transparency in Coverage Rule Published

Health Plans Required to Provide Cost Data to Members and the Public

Today, the Departments of Health and Human Services, Labor, and the Treasury (the Agencies) formally[1] published final rules adopting requirements for "Transparency in Coverage," which require health plans to make cost and claim data available under two initiatives:

- First, health plans must establish an "internet-based, self-service tool" to allow members to get real-time, accurate estimates of a member's cost-sharing liability for specific services, furnished by specific providers, at specific locations (if applicable). The estimates must take into account current deductibles and out-of-pocket limits, as well as negotiated rates and other factors that may affect the amount a member will owe.

- Second, health plans must make three "machine-readable files" available to "any person free of charge and without conditions, such as establishment of a user account, password, or other credentials." The three files are (i) in-network provider rates for covered items and services; (ii) out-of-network allowed amounts and billed charges; and (iii) negotiated rates and historical net prices for covered prescription drugs. These files must be updated monthly.

The internet-based, self-service tool must be available to members beginning on January 1, 2023, with respect to 500 specific items and services that the Agencies will post on a public website (and that are listed in the preamble to the Rules). The self-service tool must be functional for ***all*** covered items and services by January 1, 2024. The machine readable files must be posted for public access by January 1, 2022.

The final rules are published at 85 *Federal Register* 72158 (click here). Click here for my compilation of Selected Federal Health Insurance Provisions incorporating the HHS

[1] The Centers for Medicare and Medicaid Services informally published the Rules and released them to the public on October 29.

requirements into previously-published rules (or see the "Resources" page at tbixbylaw.com). (*See* first two lines under "Compiled Rules." The Rule added sections 45 C.F.R. §§ 147.210 – 212, at pages 168-178 of Volume I: Chapters 144-153 of my Compiled Rules).

Self-Service Tool for Member Cost-Sharing Information

When seeking cost-sharing information for an item or service, a member must be able to use the self-service tool to enter (i) either a billing code (*e.g.*, CPT code) or a "descriptive term" (*e.g.*, "rapid flu test") to identify the item or service; (ii) the name of the in-network provider (if applicable); and (iii) any other factors necessary for the health plan to accurately determine the member's cost sharing amount (*e.g.*, provider location, facility at which procedure is to be furnished, or dosage). The tool must also allow members to search for alternative ways to get the item or service, based on geographic proximity of in-network providers and the member's cost-sharing liability.

The self-service tool will need to provide cost sharing information that is "accurate at the time the request is made." The information must include (i) the member's cost-sharing liability; (ii) amounts based on the current status of the member's deductible and out-of-pocket limits; and (iii) either the in-network rate (the negotiated rate or fee-schedule rate as applicable) or the out-of-network allowed amount. The tool must also provide notice to members of a variety of things, such as whether the item or service is subject to prior authorization or any other "prerequisite" and the possibility of "balance billing" if the provider is out-of-network.

Health plans must also make this information available in paper form for members who request it.

Machine-Readable Data Available to the Public

Health plans will be required to post on an internet website machine-readable files containing the following information:

- **In-Network Rate File**. A file that includes information for "all covered items and services," except fee-for-service prescription drugs (information for which must be provided in the third file, described below). This information must be provided separately for each coverage option offered by the health plan (based on HIOS identifier, if available) and must be "[a]ssociated with the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code for each in-network provider." The file must also list the date on which provider contracts terminate (or specific rates otherwise expire).

- **Out-of-Network Allowed Amount File**. A file that provides historical (actual) allowed amounts and billed charges for items and services furnished by specific out-of-network providers, as applicable to each coverage option offered by the health plan (based on HIOS identifier, if available).

- **Prescription Drug Cost File**. Because pricing of prescription drugs is complicated by manufacturer list prices (AWP and WAC) and application of rebates (among other things), the Agencies determined that prescription drug cost data should include ***both*** negotiated rates ***and*** historical (actual) net prices. Thus, the Prescription Drug Cost File must include rates negotiated with specific in-network providers (*e.g.*, pharmacies), including rates based on each coverage option offered by the health plan (based on HIOS identifier, if available). The file must provide the date on which provider contracts terminate (or specific rates otherwise expire). The file must ***also*** include historical (actual) net prices for prescriptions filled by in-network providers.

Historical data reported in the Out-of-Network Allowed Amount File and the Prescription Drug Cost File must not be published unless the data includes a minimum of 20 claims (submitted by a specific provider for a particular item or service) in order to safeguard the privacy interests of individuals whose claims are involved.

Medical Loss Ratio Adjustments

The Department of Health and Human Services adjusted the formula for a health plan's Minimum Loss Ratio calculation to allow health plans to provide members incentives to use lower-cost providers. Specifically, a health plan that implements a "shared savings" plan, under which members who utilize lower-cost providers may share the cost savings with the health plan, may include the member's portion of the savings as a claim expense in the numerator of the Minimum Loss Ratio calculation. As the Department explained in the preamble to the Rule, it "made this proposal so that issuers would not be required to pay MLR rebates based on a plan design that would provide a benefit to consumers that is not currently captured in any existing MLR revenue or expense category."

The Rule amended the definition of the numerator in the Medical Loss Ratio calculation by adding a new paragraph (b)(9) to 45 C.F.R. § 158.221 (*see* page 231 of Volume II: Chapters 154-158 of my Compiled Rules).

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