Proposed Transparency Rules for Health Plans

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On November 27, 2019, the Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury (collectively, the Departments) published a proposed rule that would impose new “transparency in coverage” requirements on group health plans and health insurance carriers.

Under the proposed rule, non-grandfathered group health plans and all health insurance carriers would be required to comply with the following transparency disclosure requirements:

Information Disclosed	Who Can Access the Information	Format of Disclosure
Cost-sharing information on covered items and services.	Participants and beneficiaries (and their authorized representatives).	• Internet-based self-service tool • Paper format (upon request)
Negotiated rates with in-network providers, and historical out-of-network allowed amounts.	All consumers and members of the public.	Machine readable files.

The rule is only in proposed form, which means that group health plans and insurance carriers are not yet required to comply with the new requirements. If finalized, the new requirements would be effective for plan years beginning on or after one year following finalization of the rule. For example, if the rule is finalized on June 1, 2020, then a group health plan with a January 1 plan year would be required to comply with the new requirements on January 1, 2022.

If finalized "as-is", the requirements impose substantial new disclosure obligations on group health plans. While carriers will generally be responsible for these disclosures with respect to fully insured plans, self-funded plans will need to work with third party administrators or other vendors to meet the new requirements. The rule does not apply to excepted benefits (e.g., dental, vision, health flexible spending arrangements (health FSAs)), or to health reimbursement arrangements (HRAs) or other account-based plans that simply make a certain dollar amount available, or to short-term limited duration insurance.

The following provides highlights from the proposed rule.

Overview

The stated goal of the proposed rule is to support a market-driven health care system by giving employees and other consumers the information they need to make informed decisions about their health care purchases. For example, the rule provides participants and beneficiaries with price and benefit information in advance that can enable them to evaluate their health care options and make cost-conscious decisions. The Federal Government is of the view that price transparency will, over time, potentially lower overall health care costs in the market.

Disclosure to Participants and Beneficiaries

At the request of a participant or beneficiary (or authorized representative), a group health plan or insurance carrier must provide specified cost-sharing information with respect to a covered item or service that the individual might receive from a particular provider. The disclosure is similar to an "explanation of benefits" (or EOB), except that it is provided before medical treatment, not afterwards.

Briefly, the disclosure must include:

- An estimate of the participant's or beneficiary's cost-sharing liability at the time the request is made, considering all deductibles, coinsurance, copayments and other cost-sharing provisions under the group health plan;
- Accumulated amounts of cost-sharing that the participant or beneficiary has already incurred under the plan at the time the request is made;
- For an in-network item or service, the negotiated rate (reflected as a dollar amount) with the in-network provider;
- For an out-of-network item or service, the out-of-network allowed amount for the requested item or service if furnished by an out-of-network provider;
- If the item or service is subject to a bundled payment arrangement, cost sharing information for each item and each service within the bundle;
- Notification (if applicable) that the covered item or service is subject to concurrent review, prior authorization, step therapy protocol, or other prerequisite to coverage; and
- Notification on balance billing for out-of-network items and services, that the actual charges may be different from the estimate provided, and other required disclosures. A model notice is available.

This information must be provided in plain language through a self-service tool on an internet website that allows real-time responses based on cost-sharing information that is accurate at the time of the request. There are detailed requirements as to what the website must allow the user to do, including looking up information via a billing code (e.g., CPT code) or by using the name of the provider (both in-network and out-of-network). If requested by a participant or beneficiary (or authorized representative), the information must be mailed to the individual in paper format within two business days of receipt of the request.

The proposed rule permits fully insured group health plans to enter into a written agreement with the insurance carrier which requires the carrier to disclose the required information to participants and beneficiaries (and their authorized representatives). If the carrier fails to provide full or timely information, the carrier will be liable but not the plan. This special rule does not apply to self-funded plans. While employers sponsoring self-funded health plans may contract with third parties to provide the applicable notices, if the third-party fails to provide full or timely information on behalf of the plan, the plan (and employer) remain liable.

Disclosure to the Public

The proposed rule also requires group health plans and insurance carriers to make publicly available two machine-readable computer files which contain the following information:

1. Negotiated Rate File: A file that lists every negotiated rate under the group health plan with respect to each covered item or service furnished by in-network providers. The disclosure would include billing codes used by the plan to identify each item or service, with a plain language description of each billing code. If the plan has negotiated different rates for items or services furnished by various network providers, then each different negotiated rate must be disclosed. In addition, if the plan has negotiated a bundled payment arrangement (for example, for childbirth), then the plan must identify the items and services within the bundle by the relevant billing codes.

2. Allowed Amount File: A file that lists each unique out-of-network allowed amount in connection with covered items or services furnished by a particular out-of-network provider during the 90-day period that begins 180 days prior to the publication of the file. For example, if the group health plan received 23 claims from an out-of-network provider for rapid flu tests during the 90-day period, and the plan calculated out-of-network allowed amounts of $100 for three claims, $150 for 10 claims, and $200 for the remaining 10 claims, then it would need to disclose all of this information in the file.

The proposed rule lays out specific formats and methods for these files, which must be updated on a monthly basis. In addition, the Departments released tables that outline the proposed data elements that a plan or issuer would be required to use in each readable file.

- Negotiated Rate File, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-negotiated-rate-file.pdf

- Allowed Amount File, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-allowed-amounts-file.pdf

The proposed rule permits fully insured group health plans to enter into a written agreement with the insurance carrier which requires the carrier to disclose the two machine-readable computer files to the public. If the carrier fails to provide full or timely information, the carrier will be liable but not the plan. For self-funded plans, the rule permits the plan to reduce the burden of disclosure by entering into a HIPAA business agreement and contracting with a health care claims clearinghouse or third party administrator to disclose the information on behalf of the plan, but the plan would remain liable for any failure by the clearinghouse or administrator to comply with the new rule.

Employer Action

This summary provides a high-level overview of the very detailed proposed rule on the new transparency disclosure requirements. The Departments will collect comments on the proposed rule until January 14, 2020, and any final rule will be published at a later date.

These rules are in proposed form, which means that no action is required at this point. Employers should be aware that additional transparency disclosure requirements may be coming, and will likely add additional administrative costs and other burdens to their employer-sponsored group health plan. If the new rule is finalized, plans should have at least a year from the time the final rule is published to address compliance with any new requirements.