Federal Agencies Issue Proposed Rules Addressing Transparency in Coverage

The proposed rules on Transparency in Coverage were published by the Department of Health and Human Services, the Department of Labor and the Department of Treasury (the "Agencies") on November 27, 2019. These rules were generated in response to President Trump's June 2019 Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First. If enacted as written, the rules will provide health plan participants with greater access to health care cost information than is generally available or required today.

The Bottom Line

The rules will affect fully insured and self-insured health plans ("health plans"). For fully insured plans, the insurance carriers are responsible for meeting the requirements. The responsibility belongs to the plan administrators for self-insured plans, but the actual administration will be contractually delegated to third party administrators (TPAs) in most instances out of practical necessity.

The rules' main objective is to provide consumers (that's us) with real-time access to actual cost information, including estimated cost-sharing liability for services covered by the health plan through online tools. The Agencies believe this information is necessary for members to make informed decisions about health care including their choice of health care providers.

When, Exactly?

These are only proposed rules, so don't look for changes right away. The rules do not go into effect until one year after the date the final rules are published, and they will apply to health plans as of their first plan year beginning on or after that date.

Summary of Proposed Rules

Non-grandfathered health plans[1] will need to provide specific information to participants, including:

- The estimated cost-sharing liability, such as deductibles, coinsurance and copays a participant is responsible for paying for a covered item or service;
- The accumulated amounts applied to cost limits such as deductibles and out-of-pocket cost limits to date;

[1] This refers to grandfathered status under the Affordable Care Act.

- The negotiated rate that the health plan agreed to pay for a service with an in-network provider;[2]
- The out-of-network allowed amount and the participant's cost sharing responsibility if the member goes to an out-of-network provider;
- If the service is part of a bundled payment agreement, all the services that are included in the bundled payment agreement;
- Whether the service is subject to any medical management procedures, such as concurrent review, prior authorization, step therapy, etc.; and
- Other information that may affect cost, including a statement that out of network providers may balance bill the participant and that the cost-sharing estimates are not a guarantee of coverage.[3]

Reactions

If the rules are finalized without changes, we expect insurance carriers, TPAs, and price transparency vendors will challenge public access to network negotiated discounted fees based on the arguments that: (1) such information is proprietary; and (2) this will weaken competitive advantages which is the opposite effect intended by the Executive Order. Also, the existing proprietary systems used by most of these entities do not include all the information required by the rules meaning the entities will need to invest to update their tools.[4] In addition to affecting health plans, the rules may also affect health care providers by pressuring them to reduce and/or justify charges for services.

Note: In theory, transparency should lead to lower health plan costs if it causes participants to use lower cost, high quality providers. This may be offset to some extent if it also leads to participants seeking more health care.

Model Disclosure Notice

The proposed rules include a model notice that should be tailored to best fit the health plan. The tailored notice should be written in plain language (typically, at an 8th grade reading level), and cannot conflict with the model language in the notice.

The Agencies also proposed the methods by which the notice can be delivered, either through a web-based tool – a mobile application should suffice – ***or*** in paper form. If a member does not have internet access, the notice must be provided in paper within two (2) days of the request, free of charge.

[2] This is not required if the negotiated rate does not affect the participant's estimated cost.
[3] The proposed rules do not address health outcomes, but we expect insurance carriers, TPAs, and price transparency vendors will also provide this information.
[4] This expense may be passed through to health plans in the form of higher premiums or other fees.

Rate Disclosure

Health plans will also be required to disclose in-network negotiated rates for services[5] and historically-approved amounts paid for out of network services.[6] This information must be provided on two machine readable files, posted on their website for public access, and updated monthly. The disclosure must be in plain language, describing the service, billing codes, plan information, in-network rates, and out of network approved amounts.

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[5] The proposed regulations would require health plans to disclose the contracted amounts in-network providers are paid for covered items and services. The Agencies provided a table of proposed data elements.
[6] The proposed regulations would require health plans to disclose allowed amounts for out-of-network providers. The Agencies provided a table of proposed data elements. As proposed, the allowed amount would be reported as the aggregate of the actual amount the health plan paid to the provider for an item or service, plus the consumer's (or responsible party's) share of the cost. To protect patient privacy, there would need to be at least ten different out of network claims for payment.