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Policy Update

Transparency in Coverage Proposed Rule: What You Need to Know

Summary

On November 15, 2019, the US Department of Health and Human Services (HHS), the US Department of Labor, and the US Department of the Treasury released the proposed rule Transparency in Coverage. The proposed rule outlines new reporting requirements for group health plans and issuers in the individual and group markets regarding beneficiary cost-sharing, in-network provider negotiated rates and historical out-of-network allowed amounts. The rule also proposes changes to medical loss ratio (MLR) rules.

The proposed rule includes requests for information (RFIs) on disclosure of pricing information through a standards-based application programming interface (API) and on provider quality measurement and reporting.

Comments on the proposed rule are due January 14, 2020.

Context

Key Takeaway: The Trump Administration continues its pursuit of transparency and beneficiary empowerment.

In June 2019, President Trump issued the Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First. The order directs the secretaries of the US Departments of Labor, HHS and Treasury to issue an advanced notice of proposed rulemaking soliciting comments on a proposal to require healthcare providers, health insurance issuers and self-insured group health plans to provide or facilitate access to information about out-of-pocket costs for items and services to patients before they receive care. The rule aims to provide consumers with information they need to make informed healthcare decisions and purchases.

This proposed rule was released alongside a final rule implementing transparency requirements for hospital items and services.

Plan Reporting Requirements

Key Takeaway: Group health plans and insurance issuers in the individual and group market will be required to report beneficiary cost-sharing, in-network provider negotiated rates and historical out-of-network allowed amounts.

The departments propose seven elements that a plan or issuer must disclose, upon request, to a participant, beneficiary or enrollee. The plans must also disclose a covered item or service to the extent relevant to the individual's cost sharing liability for the item or service.

- *Estimated cost-sharing liability* – the amount a participant, beneficiary or enrollee is responsible for paying for a covered item or service under the plan
- *Accumulated amounts* – the financial responsibility the participant, beneficiary or enrollee has incurred at the time the request for cost-sharing information is made
- *Negotiated rate* – the amount a plan, issuer or third party has contractually agreed to pay an in-network provider for a covered item or service pursuant to the agreement between the provider and the plan, issuer or third party
- *Out-of-network allowed amount* – the maximum amount a plan or issuer would pay for a covered item or service furnished by an out-of-network provider
- *Items and services content list* – list of covered items and services for which cost-sharing information is disclosed
- *Notice of prerequisites to coverage* – certain prerequisites or requirements relating to medical management techniques for covered items and services that must be satisfied before a plan or issuer will cover the item or service
- *Disclosure notice* – plain language communication containing specific disclosures related to out-of-network billing and other required disclosure language.[1]

This personalized information would have to be made available online through a self-service tool and in hard copy.

Plans and issuers also would be required to publish two machine-readable files: the Negotiated Rate File, with information on rates negotiated with in-network providers, and the Allowed Amount File, with historical data showing allowed amounts for covered item and services furnished by out-of-network providers. Each of these files also have required content:

- Name or identifier for each plan option or coverage
- Billing codes
- Negotiated rates or out-of-network allowed amounts

The reporting requirements would be effective for plan years beginning one year after the finalization of this rule or later.

Throughout the proposed rule, HHS highlights the potential burden on plans and issuers to develop, create, format and upload detailed data that would be meaningful to the consumer. Plans and issuers are encouraged to provide thoughtful feedback on burden and feasibility, and to suggest alternatives.

[1] The departments proposed a model disclosure notice that can be obtained at http://www.cms.hhs.gov/PaperworkReductionActof1995.

Changes to Medical Loss Ratio

Key Takeaway: Issuers of new or different plans that include provisions encouraging consumers to shop for services from lower-cost, higher-value providers, and that share the resulting savings with consumers, would be able to take credit for the savings in their MLR calculations.

The MLR requirement limits the portion of premium dollars health insurers may spend on administration, marketing and profits. The Affordable Care Act requires that most insurance companies spend at least 80% (for individuals and small groups) or 85% (for large groups) of their premium income on clinical services and quality improvement activities, and the remaining 15% to 20% for administration, marketing and profit.

Under the proposed rule, HHS would use its authority to account for special circumstances of certain plans that provide shared savings to consumers who choose high-value, low-cost providers by allowing plans to take credit for such shared savings in the issuers' MLR calculations. Beginning with the 2020 MLR reporting year, an issuer may include in the numerator of the MLR shared savings payments to an enrollee that result from the enrollee choosing high-value, lower-cost care.

Applicability

Key Takeaway: This rule applies to group health plans and health insurance issuers in the group and individual markets. However, it does not apply to Medicare Advantage, short-term limited duration insurance plans; health reimbursement arrangements; or other account-based group health plans, grandfathered health plans or excepted benefits. The departments seek comment on whether certain types of downstream plan arrangements should also be exempt or otherwise have modified requirements under these rules (*e.g.*, Accountable Care Organizations or plan structures such as staff model HMOs).

Requests for Information

Key Takeaway: The proposed rule also includes an RFI and request for comment on disclosure of pricing information through a standards-based API and on provider quality measurement and reporting.

The rule includes an RFI on developing a future rule that would require cost-sharing, in-network negotiated rates and out-of-network allowed amounts available in discrete data elements through a standards-based API. Standards-based APIs allow software programs to interact with one another through uniform standards and data sharing applications.

The proposed rule also includes an RFI on imposing reporting requirements regarding quality information for providers of healthcare items and services. The rule outlines eight specific quality reporting questions for public comments, including:

- Whether quality reporting should be standardized across plans
- What existing quality reporting measures are most useful

- What quality reporting is feasible
- How do plans already use quality data
- What gaps exists in current quality measures.

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