This Webinar Will Start Momentarily.

Thank you for joining us!

Health Plan Transparency Requirements

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Presented by the Regulatory and Legislative Strategy Group

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Agenda

1. Transparency Requirements
2. Surprise Medical Billing
3. Price Comparison Tool
4. Prescription Drug Reporting
5. Gag Clause Attestations

Transparency Requirements

Transparency Requirements - Overview

- **ID Card Requirement**
  - Group health plans with plan years beginning on or after 1/1/2022
  - Must include the following information: IN/OON deductibles, OOP maximums, contact information for consumer assistance
- **Continuity of Care**
  - Group health plans with plan years beginning on or after 1/1/2022
  - Must implement protections to ensure continuity of care in instances where termination of contractual relationships result in changes in provider or facility network status
- **Advanced EOB -** Not required until future rulemaking is completed

Transparency Requirements - Overview

- **In-Network Provider Directories**
  - » Group health plans with plan years beginning on or after 1/1/2022
  - » Plans and issuers must establish:
    1. a database listing health care providers and facilities that have contracted with the provider network,
    2. a process to verify and update provider directories at least once per 90 days and within 2 business days for notice of removal of provider or facility from database,
    3. a protocol for timely (within 1 business day) response to individual enrollee inquiries through a telephone call, electronic, web-based or internet-based means and retention of communication in individual's files for at least 2 years following response
  - » Must be available on group health plan's public website when a third-party fails to provide necessary information
  - » Standards for cost-sharing for services provided based on reliance on incorrect provider information:
    - ❑ Plan or coverage shall not impose cost sharing that exceeds the cost-sharing amount that would apply to services by a participating provider (copayments, deductibles, coinsurance, out-of-pocket maximum)
  - Good faith compliance with law required pending issuance of regulations

Transparency Rules

Publicly Available Machine-Readable Files

- One file must include the rates negotiated between the plan and in-network providers for all covered items and services; another file must include data showing the historical payments to, and billed charges from out-of-network providers
- Previous deferral of enforcement for prescription drug data eliminated by FAQs Part 61 - technical requirements and implementation timeline will be addressed in future guidance
- Posting was due by later of 7/1/22 or first day of 2022 plan year and routinely updated
- Applies to group health plans (as well as carriers)
  - Fully insured plans have no responsibility if the carrier agrees in writing to post the files on behalf of the plan
  - Self-insured plans can comply by entering a written agreement with TPA to post the files, but the plan remains ultimately responsible for compliance
  - Link to carrier's/TPA's website only if the plan has its own public website

Surprise Medical Billing

Surprise Medical Billing Rules

- Effective for plan years beginning on or after January 1, 2022
- Rules generally apply to all group medical plans (also apply to health care providers)
- In-network cost-sharing limitations for specific claims
  - » Rules apply to three types of claims:
    - Out-of-network (OON) emergency services
    - Services provided by an OON provider during a visit to an in-network facility (unless notice and consent)
    - OON air ambulance services

Surprise Medical Billing Rules

NOTICE REQUIREMENTS

- Post information about rules on a public website of the plan or issuer
    - If a ***plan*** does not have a public website, requirement can be satisfied by entering into a written agreement with a health insurance carrier or a third-party administrator (TPA) that posts the information on the carrier's/TPA's public website that is usually accessible by participants
    - No requirement to create a public website for plan if agreement is entered
    - If the insurance carrier/TPA fails to abide by its agreement to post the information on behalf of the plan, the plan is ultimately in violation of the disclosure requirement
- Include information on each explanation of benefits (EOB) for an item or service with respect to which the surprise billing requirements apply
- No specific requirement to distribute notice to all participants

Independent Dispute Resolution (IDR) Process

Background

- 2021 - the regulatory agencies published interim final regulations implementing the IDR process as part of the federal surprise billing rules
- Rules govern the amount a group health plan must pay the out-of-network provider/facility when the law applies to a claim.
  - Amount determined by reference to an All-Payer Model Agreement or a specified State law – when neither applies, group health plans and providers determine amount by following IDR process

Final Rule

- For disputes initiated on or after 1/22/2024, the administrative fee is $115 per party per dispute
- Certified IDR entities may charge a fixed fee ranging from $200-$840 for single determinations ($268-$1,173 for batched determinations)
  - Can include $75-$250 fixed tiered fee for every additional 25 line items in batched disputes with more than 25 line items

Price Comparison Tool

Price Comparison Tool

- Allows participants to compare the amount of cost-sharing that the individual would be responsible for paying under the plan when receiving a specific item or service by a particular provider
- Self-service tool available on internet website (and by telephone per CAA)
  - Real-time responses as of the date of the request
  - Must be provided in paper form upon request
  - Mobile app alone is insufficient
  - Searchable by:
    - Covered item or service,
    - All in-network providers, or
    - All out-of-network providers.

Price Comparison Tool

- Effective for plan years beginning on or after January 1, 2023
  - » Must disclose cost-sharing and pricing for 500 specific items and services
  - » List available at http://www.cms.gov/healthplan-price-transparency/resources/500-items-services
  - » Updated quarterly
- **Effective for plan years beginning on or after January 1, 2024**
  - » Must disclose cost-sharing and pricing for ***all*** covered items and services
- Rules regarding duplication
  - » Plan sponsor can shift responsibility to third party via written agreement
  - » Sponsors of self-insured plans retain ultimate responsibility for compliance

Price Comparison Tool

Tool Must Provide the Following Information:

1. Estimated cost-sharing liability ($) for a covered item or service, including all items and services for which benefits are available under the medical plan (including drugs and durable medical equipment)
2. Participant's accumulated deductible, out-of-pocket maximum and treatment limitation amounts
3. The in-network rate for the requested covered item or services (even if it is not the rate used to calculate cost-sharing liability) and the underlying fee schedule rate to the extent it is different from the negotiated rate
4. The out-of-network allowed amount when the covered item or service is received from an out-of-network provider
5. If the item or service is part of a bundled payment arrangement, a list of the items or services included in the bundled payment arrangement
6. A list of any prerequisites required for plan coverage (e.g., prior authorization, concurrent review, fail-first medical policy or step-therapy drug protocols)
7. Disclosure notice that contains specific information (e.g., the notice must state that the actual charges for a participant's covered item or service may be different from the estimate of cost-sharing liability provided by the self-service tool) – See Model Notice

RxDC Reporting

General Overview of RxDC Requirements

- Added to ERISA, Internal Revenue Code and PHSA by CAA of 2021
- Generally due by June 1st of the year following the applicable reporting year (i.e., immediately preceding calendar year)
- Applies to both grandfathered and non-grandfathered fully insured and self-insured group health plans (regardless of size), but:
  - » Does not apply to HIPAA excepted benefits (e.g., most dental and vision plans; fixed indemnity plans; disease-specific insurance)
  - » Does not apply to account-based plans (e.g., HRAs and health FSAs)
  - » Does not apply to retiree-only plans
- Applies to plans sponsored by private sector employers, governmental employers, and churches and conventions and associations of churches
- Applies regardless of employer's size

Who is handling the reporting?

- Using a third party (e.g., insurance carrier, TPA, PBM, etc.)
  - Regulations allow **fully insured** group health plans to shift all responsibility to carrier if carrier agrees to perform reporting pursuant to a written agreement
  - Regulations allow a third party to perform the reporting on behalf of a **self-insured** group health plan pursuant to a written agreement, but group health plan (and plan sponsor) retains ultimate responsibility if the third party fails to comply
  - Plan sponsor could be a reporting entity if third parties do not agree to submit all data files
- Carrier/TPA/PBM will not have all this information (especially premium information)
  - Plan sponsor may need to file D1 or provide information to carrier/TPA/PBM
  - Carriers/TPAs/PBMs generally impose deadlines for providing information
    - What if employer misses deadline? Depends on specific circumstances

Multiple Reporting Entities

Rules regarding multiple files

- Instructions indicate that if there are multiple reporting entities that they should work together to submit only one data file of each type for the same plan, issuer, or carrier
  - Ex: behavioral health benefit begins data submission with its information, and then gives the data file to another reporting entity to complete and file through HIOS
- If entities are unwilling/unable to work together, then more than one reporting entity may submit the same type of data file on behalf of the same plan/issuer/carrier
  - Ex: behavioral health benefit submits its information, and the medical benefit plan submits its information under D2
- Special rule if vendors change mid-year – multiple reporting entities can submit the same data file for different portions of the year
  - Ex: previous medical benefit plan submits information up to X date, and then second medical benefit plan provides information for remaining portion of reference year) or previous carrier/issuer/TPA can provide data to new carrier/issuer/TPA.

What Information Must Be Reported

Five General Categories of Information

1. Group Health Plan List – File P2
2. Premiums and Life Years (Covered Lives) – File D1
3. Medical Spending by Category – File D2
4. Rx Cost Information – Files D3-D8
5. Narratives

Carriers, TPAs and PBMs that file on behalf of group health plans will generally aggregate data contained in Files D2-D8 by market segment and state.

Plan List

- P2 applies to group health plans
- Must be submitted by any reporting entity that submits a file on behalf of a group health plan
- Includes various pieces of plan identifying information (e.g., plan name, plan number, plan year, plan sponsor name, etc.) and information about issuer, TPA and/or PBM
  - » Plan sponsor may need to provide some of this information to carrier/TPA/PBM if the carrier/TPA/PBM is handling the reporting
- P2 file also indicates which additional files are being included with the reporting entity's submission

D1: Life Years and Premiums

Six Data Elements

1. Life Years = Average number of members (employees and dependents) throughout the year
   - First, calculate total member months
     - » Count the number of members covered on a given day of each month of the year
     - » Add the count for each month together
   - Then divide total member months by 12
2. Earned Premium (FI) or Premium Equivalent (SI)
   - Earned Premium = All money paid to carrier
   - Premium Equivalent = Total cost of providing and maintaining coverage, including claims costs, administrative costs, Administrative Services Only (ASO) and other TPA fees and stop loss premiums
     - » Based on actual experience, not rates determined prior to the start of the plan year to establish employer funding, employee contributions or COBRA rates.
3. Admin fees paid (aggregate for plan)
4. Stop loss premium paid (aggregate for plan)
5. Average monthly premium paid by members
6. Average monthly premium paid by employers

New for 2023 Reference Year

- Total monthly premiums for fully insured plans are now reflected by taking the total annual premium and dividing it by 12 (rather than reporting average monthly premium on per-member, per month, basis).
- For self-insured plans, premium equivalents have been further clarified in instructions, and plans may now report premium equivalents on a “cash basis” meaning they can be based upon paid claims rather than on an incurred basis

Data Files (D2 – D8)

D2

- Medical spending by category: hospital, primary care, specialty care, other medical costs and services, and medical benefit drugs (known amounts and estimated amounts)

D3 through D8

- Top 50 Brand Drugs, Top 50 Most Costly Drugs, Top 50 Drugs by Spending Increase, Rx Totals, Rx Rebates by Therapeutic Class, Rx Rebates for the Top 25 Drugs
- Does not include Rx drugs covered under a medical benefit (so no coordination needed between PBM and TPA) to complete D3 through D8

Updated RxDC Reporting Instructions (1/24)

- Key material changes:
  - Beginning with RxDC reporting for the 2023 calendar year reference year, CMS will begin enforcing the previously-suspended aggregation restriction
    - Requires the most granular aggregation level that applies to all healthcare spending (D2 file) must be used when more than one reporting entity submits the same files on behalf of the same plan, issuer or carrier
    - Impacts Rx cost data (files D1 and D3-D8)

      Examples:
      - If D2 reflects data at the plan sponsor FEIN level, the D1 and D3-D8 files must also be at the plan sponsor level
      - If D2 reflects data at the TPA, PBM or carrier level, the reporting entity may choose to aggregate the D1 and D3-D8 files at the same level as the D2 file or aggregate at the level of the plan sponsor's FEIN
    - Reporting entities submitting different files are not required to aggregate at the same level

      Example:
      - Two entities (TPA and PBM) are each reporting separately. TPA submits D2 file under its EIN. PBM submits D3-D8 files
      - PBM may aggregate data at the same level as the TPA or at the plan sponsor's FEIN level

Updated RxDC Reporting Instructions (1/24)

Additional updates to RxDC Reporting instructions clarified how reporting entities should:

- Populate the benefit carve-out field in the P2 (Plan List) file
- Report information in prior years column in D5 file how to represent plans when the plan contributes to the prior year
- Report retained rebate information when exact amounts are unknown

Also added:

- Clarification that benefits for medical devices, nutritional supplements and OTC drugs are excluded from the Rx D3-D5 and D7-D8 files, except where the product's NDC is on the CMS Drug and Therapeutic Class Crosswalk
- Enrollment column to D6 file

Penalties

- Regulatory agencies have not provided guidance regarding enforcement or potential penalties
- RxDC reporting requirement added as Section 9825 of the Internal Revenue Code
  - Section 9825 is part of Chapter 100
  - Section 4980D imposes an excise tax on any failure of a group health plan to meet the requirements of Chapter 100
  - Excise tax amount is $100 for each day in the noncompliance period with respect to each individual to whom such failure relates
  - Unclear as to which individuals a failure to comply with RxDC reporting would relate, so not clear how IRS would calculate excise tax

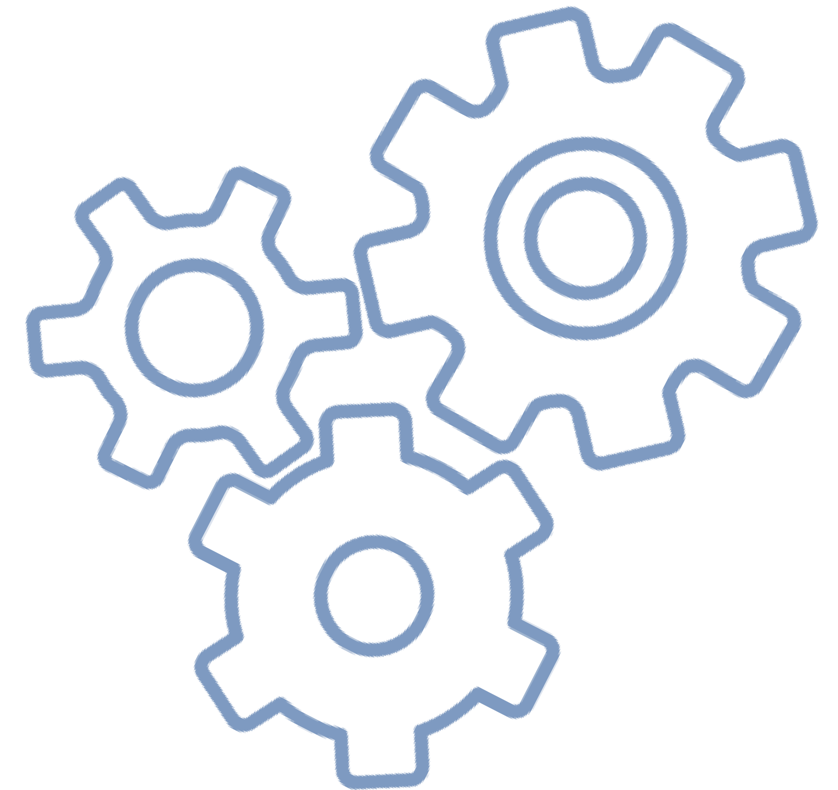
Filing Procedure

Submit Data Through the RxDC Module in the Health Insurance Oversight System (HIOS)

- Instructions for using the RxDC module are in the User Manual

Process for Registering

- Must have a HIOS account to file reports
- Instructions for creating an account are in the HIOS Portal User Manual
  - Instructions contain contact information for additional help



Summary

- Plan sponsors need to determine whether carrier, TPA and/or PBM will be performing reporting on behalf of the plan
  - If so, enter into a written agreement
- Will all data files be covered by third-party reporting?
  - If so, determine what information needs to be provided to carrier/TPA/PBM for it to complete the report
  - If not, plan sponsor needs to create a HIOS account and prepare to file any missing files on its own
- Employers entering into a written agreement with a carrier/TPA/PBM/vendor should make sure they follow deadlines to get information third-party if they plan to have them report for the health plan
  - Employers who miss the deadline may have to report themselves if an exception cannot be made with the carrier/TPA/PBM/vendor

Gag Clause Attestations

General Overview of Gag Clause Attestation Requirements

- Prohibition on gag clauses was effective December 27, 2020
- Applies to fully insured and self-insured group health plans, including plans subject to ERISA, non-Federal governmental plans and church plans
  - » Does not apply to plans providing excepted benefits and account-based plans
- A plan may not enter into an agreement regarding a provider network that would directly or indirectly restrict the plan from:
  - » Providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees of the plan or coverage;
  - » Electronically accessing de-identified claims and encounter information or data for each enrollee in the plan, upon request and consistent with applicable federal law; and
  - » Sharing information or data described above, or directing that such data be shared, with a HIPAA business associate.

Recent Regulatory Guidance

FAQ About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 57

- Issued February 23, 2023
- Provides examples of prohibited gag clauses
  - A provision in a contract between a TPA and group health plan indicating that the plan may not share information regarding the rates the TPA pays to providers with participants and beneficiaries
  - A provision in a contract between a TPA and group health plan providing that the plan sponsor’s access to provider-specific cost and quality of care information is at the discretion of the TPA

Attestations

- A group health plan must annually submit to the DOL an attestation that it is complying with these requirements
- Deadline: A plan must attest each year by **December 31st** for the period beginning with the end date of the most recent previous attestation through the date of the current attestation
- Attestations submitted via a website (https://hios.cms.gov/HIOS-GCPCA-UI)
- Departments have issued instructions, a system user manual and a Reporting Entity Excel Template
  - Available at: https://www.cms.gov/cciio/programs-and-initiatives/other-insuranceprotections/gag-clause-prohibition-compliance
- Third party can submit on behalf of group health plan
  - **Fully Insured** – Submission by carrier constitutes compliance by plan
  - **Self-Insured** – Written agreement; plan retains ultimate responsibility to ensure compliance

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