HFMA
Health Plan Price Transparency Requirements
Final Rule

Overview. On October 29, 2020, CMS issued a final rule requiring health plans to make an online price transparency tool that provides cost sharing and other information available to their members. For plan years starting on or after January 1, 2023, the rule requires health plans to offer an online shopping tool allowing consumers to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket (OOP) cost for 500 of the most shoppable items and services. The following year (effective for plan years starting on or after January 1, 2024), these shopping tools will be required to show the OOP costs for the remaining procedures, drugs, durable medical equipment and any other item or service they may need.

Plans are also required to make hardcopy OOP estimates available to members, if requested. As described below in detail, the rule defines and prescribes the key elements that a plan must provide its members.

Additionally, by January 1, 2022, the rule requires plans to make publicly available three standardized and regularly updated data files. The first file will show negotiated rates for all covered items and services between the plan or issuer and in-network providers. The second file will show both the historical payments to, and billed charges from, out-of-network providers. And finally, the third file will detail the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

The rule modifies the medical loss ratio (MLR) calculation to allow plans to create benefit designs that reward members for choosing lower-cost providers. The rule applies to all health plans with the exception of grandfathered plans, excepted benefits, health reimbursement arrangements or other account-based plans, or short-term limited duration plans.

Disclosure of OOP Estimates. For plan years beginning on or after January 1, 2023, health plans and issuers must make OOP estimates (inclusive of any cost-sharing reductions) available to beneficiaries for 500 items and services. OOP estimates for all other items and services must be available for plan years beginning on or after January 1, 2024. Plans must make the following data elements, which are accurate at the time of the request, available to their members for covered items and services for a particular provider (or providers). The estimates must be available online and via mail upon request. Key terms are defined in Appendix 1.

- *OOP cost sharing*: An estimate of the participant's or beneficiary's cost-sharing liability for a requested covered item or service provided by a provider or providers, which is calculated based on the data elements below.
    - Accumulated amounts: The amount of financial responsibility a participant, beneficiary or enrollee has incurred at the time a request for cost-sharing information is made, with respect to a deductible or OOP limit. See Appendix 1 for a detailed definition.

- In-network rate: Comprised of the following elements, as applicable to the group health plan's or health insurance issuer's payment model:
    - **Negotiated rate**, reflected as a dollar amount, for an in-network provider or providers for the requested covered item or service; this rate must be disclosed even if it is not the rate the plan or issuer uses to calculate cost-sharing liability
    - **Underlying fee schedule rate**, reflected as a dollar amount, for the requested covered item or service, to the extent that it is different from the negotiated rate.
- Out of network (OON): Allowed amount or any other rate that provides a more accurate estimate of an amount a group health plan or health insurance issuer will pay for the requested covered item or service, reflected as a dollar amount, if the request for cost-sharing information is for a covered item or service furnished by an out-of-network provider; provided, however, that in circumstances in which a plan or issuer reimburses an out-of-network provider a percentage of the billed charge for a covered item or service, the out-of-network allowed amount will be that percentage.
- *Services included in estimate*: If a participant or beneficiary requests information for an item or service subject to a bundled payment arrangement that includes the provision of multiple covered items and services, a list of the items and services for which cost-sharing information is being disclosed. If the bundled payment arrangement includes items or services that have a separate cost-sharing liability, the group health plan or health insurance issuer must provide estimates of the cost-sharing liability for the requested covered item or service, as well as an estimate of the cost-sharing liability for each of the items and services in the bundled payment arrangement that have separate cost-sharing liabilities.
- *Service Subject to Prerequisites*: If applicable, a notification that coverage of a specific item or service is subject to a prerequisite.
- *Other Notices*: The plan must make the following disclosures to its members in plain language:
    - *Potential for Surprise Bills*: OON providers may bill participants or beneficiaries for the difference between a provider's billed charges and the sum of the amount collected from the group health plan or health insurance issuer, and from the patient in the form of a copayment or coinsurance amount, and that the cost-sharing information provided does not account for these potential additional amounts. This statement is only required if balance billing is permitted under state law.
    - *Actual Cost Sharing May Be Different from Estimate*: Actual charges for a participant's or beneficiary's covered item or service may be different from an estimate of cost-sharing liability provided, depending on the actual items or services the participant or beneficiary receives at the point of care.

- *Benefits Not Guaranteed*: The estimate of cost-sharing liability for a covered item or service is not a guarantee that benefits will be provided for that item or service.
- *Calculation of OOP Maximum*: A statement disclosing whether the plan counts copayment assistance and other third-party payments in the calculation of the participant's or beneficiary's deductible and OOP maximum.
- *Preventive Services*[1]: For items and services that are recommended preventive services, a statement that an in-network item or service may not be subject to cost-sharing if it is billed as a preventive service if the group health plan or health insurance issuer cannot determine whether the request is for a preventive or non-preventive item or service.
- *Other Information as Appropriate*: Any additional information that the group health plan or health insurance issuer determines is appropriate, provided the additional information does not conflict with the information required to be provided in the estimate.

Required disclosure formats. Plans are required to provide OOP spending estimates both in an online tool and in paper format. Below are specific details about each format.

Internet-based self-service tool. The information plans are required to provide their members must be made available in plain language, without subscription or other fee, through a self-service tool on an Internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request. Group health plans and health insurance issuers must ensure that the self-service tool enables users to perform specific types of searches, as described below.

- Search by covered item/service: Users must be able to search for cost-sharing information for a covered item or service provided by a specific in-network provider, or by all in-network providers, by inputting:
  - *Applicable billing code*: A billing code (such as CPT code 87804) or a descriptive term (such as "rapid flu test"), at the option of the user
  - *Provider name*: The name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider
  - *Facility name or other factors*: Other factors utilized by the plan or issuer that are relevant for determining the applicable cost-sharing information (such as location of service, facility name or dosage)

[1] For requested items and services that are recommended preventive, if the group health plan or health insurance issuer cannot determine whether the request is for preventive or non-preventive purposes, the plan or issuer must display the cost-sharing liability that applies for non-preventive purposes. As an alternative, a group health plan or health insurance issuer may allow a participant or beneficiary to request cost-sharing information for the specific preventive or non-preventive item or service by including terms such as "preventive," "non-preventive" or "diagnostic" as a means to request the most accurate cost-sharing information.

- OON allowable: Users must be able to search for an OON allowed amount for a covered item or service provided by OON providers by inputting:
    - *Applicable billing code*: A billing code or descriptive term, at the option of the user; and
    - *Other factors*: Other factors utilized by the plan or issuer that are relevant for determining the applicable OON allowed amount (such as the location in which the covered item or service will be sought or provided).

- Geographic/OOP cost relevance sorting: Users must be able to refine and reorder search results based on geographic proximity of providers, and the amount of the participant's or beneficiary's estimated cost-sharing liability for the covered item or service, to the extent the search for cost-sharing information for covered items or services returns multiple results.

Paper method. Information required under the final rule must be made available in plain language, without a fee, in paper form at the request of the participant or beneficiary. The group health plan or health insurance issuer may limit the number of providers to no fewer than 20 providers per request. The group health plan or health insurance issuer is required to provide the same cost-sharing information as is provided online (described above) in paper form, pursuant to the individual's request, and mail the information no later than 2 business days after an individual's request is received.

To the extent participants or beneficiaries request disclosure other than by paper (for example, by phone or e-mail), plans and issuers may provide the disclosure through another means, provided the participant or beneficiary agrees that disclosure through such means is sufficient to satisfy the request and the request is fulfilled at least as rapidly as required for the paper method.

Public disclosure of in-network provider negotiated rates and OON allowed amounts for covered items and services. For plan years beginning on or after January 1, 2022, a group health plan or health insurance issuer must make available on the internet the information below in three machine-readable files.

- *In-network negotiated rate file*. Includes all covered items and services, except for prescription drugs that are subject to a fee-for-service reimbursement arrangement (included in the prescription drug machine readable file). This file must include all the following data elements:

    - Plan/employer identifier: For each coverage option offered by a group health plan or health insurance issuer, the name and the 14-digit Health Insurance Oversight System (HIOS) identifier, or, if the 14- digit HIOS identifier is not available, the 5-digit HIOS identifier, or if no HIOS identifier is available, the Employer Identification Number (EIN).

- Service identifier: A billing code, which in the case of prescription drugs must be a National Drug Code (NDC), and a plain language description for each billing code for each covered item or service under each coverage option offered by a plan or issuer.

- Negotiated rates: All applicable rates, which may include one or more of the following: negotiated rates, underlying fee schedule rates or derived amounts. If a group health plan or health insurance issuer does not use negotiated rates for provider reimbursement, then the plan or issuer should disclose derived amounts to the extent these amounts are already calculated in the normal course of business. If the group health plan or health insurance issuer uses underlying fee schedule rates for calculating cost sharing, then the plan or issuer should include the underlying fee schedule rates in addition to the negotiated rate or derived amount. Applicable rates, including for both individual items and services and items and services in a bundled payment arrangement, must:

    - *Be Shown as Dollar Amounts*: Reflected as dollar amounts with respect to each covered item or service that is furnished by an in-network provider. If the negotiated rate is subject to change based upon participant or beneficiary-specific characteristics, these dollar amounts should be reflected as the base negotiated rate applicable to the item or service prior to adjustments for participant or beneficiary-specific characteristics.

    - *Provider Specific*: Associated with the National Provider Identifier (NPI), Tax Identification Number (TIN) and Place of Service Code for each in-network provider.

    - *Disclose Period Rate Is Valid:* Associated with the last date of the contract term or expiration date for each provider-specific applicable rate that applies to each covered item or service.

    - *Indicate Payment Methodology:* Indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model (such as capitation or a bundled payment arrangement) applies.

- *OON allowed amount file*. The OON file must include the following data elements:

    - Plan/employer identifier: For each coverage option offered by a group health plan or health insurance issuer, the name and the 14-digit HIOS identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or, if no HIOS identifier is available, the EIN.

- Service identifier. A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for each billing code for each covered item or service under each coverage option offered by a plan or issuer.

- Unique OON allowed amounts. Each unique OON allowed amount must be:

  - *Shown as Dollar Amounts*: Reflected as a dollar amount, with respect to each covered item or service that is furnished by an OON provider.
  - *Provider Specific*: Associated with the NPI, TIN, and Place of Service Code for each OON provider.

  Plans must exclude payment of OON allowed amounts for items/services with fewer than 20 different claims for payments under a single plan or coverage from amounts listed in the OON file. The rule states that nothing in this provision requires the disclosure of information that would violate any applicable health information privacy law. Health insurance issuers, service providers or other parties with which the group health plan or issuer has contracted may aggregate out-of-network allowed amounts for more than one plan or insurance policy or contract.

- *Prescription drug machine-readable file*: The prescription drug file must include the following data elements:

  - Plan/employer identifier: For each coverage option offered by a group health plan or health insurance issuer, the name and the 14-digit HIOS identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or, if no HIOS identifier is available, the EIN.

  - Drug Code: The NDC, and the proprietary and nonproprietary name assigned to the NDC by the Food and Drug Administration (FDA), for each covered item or service under each coverage option offered by a plan or issuer that is a prescription drug.

  - Current negotiated price: The negotiated prices must be reflected as a dollar amount, with respect to each NDC that is furnished by an in-network provider, including an in-network pharmacy or other prescription drug dispenser. The price must be associated with the NPI, TIN, and Place of Service Code for each in-network provider, including each in-network pharmacy or other prescription drug dispenser. The file must include the last date of the contract term for each provider-specific negotiated rate that applies to each NDC.

  - Historical net prices: Historical prices must be reflected as a dollar amount, with respect to each NDC that is furnished by an in-network provider, including an in-network pharmacy or other prescription drug dispenser. The historical price must be

associated with the NPI, TIN, and Place of Service Code for each in-network provider, including each in-network pharmacy or other prescription drug dispenser. Plans must exclude the historical net price for drugs with fewer than 20 different claims for payments under a single plan or coverage from amounts listed in the file. The rule states that nothing in this provision requires the disclosure of information that would violate any applicable health information privacy law.

- *Required method and format.* The files containing the information described above must be publicly available and accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file. A group health plan or health insurance issuer must update the machine-readable files and information described above monthly. The group health plan or health insurance issuer must clearly indicate the date that the files were most recently updated.

Revised MLR calculation for shared savings payment to enrollees who choose high-value providers: Beginning with the 2020 MLR reporting year, an issuer may include in the numerator of the MLR any shared savings payments the issuer has made to an enrollee as a result of the enrollee choosing to obtain healthcare from a lower-cost, higher-value provider.

Appendix 1. Key Terms Defined in the Final Rule

1) *Accumulated amounts*: The amount of financial responsibility a participant, beneficiary or enrollee has incurred at the time a request for cost-sharing information is made, with respect to a deductible or OOP limit. If an individual is enrolled in other than self-only coverage, these accumulated amounts shall include the financial responsibility a participant, beneficiary or enrollee has incurred toward meeting his or her individual deductible or OOP limit, as well as the amount of financial responsibility that all the individuals enrolled under the plan or coverage have incurred, in aggregate, toward meeting the other than self-only deductible or OOP limit, as applicable.

   Accumulated amounts include any expense that counts toward a deductible or OOP limit (such as a copayment or coinsurance), but exclude any expense that does not count toward a deductible or OOP limit (such as any premium payment, OOP expense for OON services, or amount for items or services not covered under the group health plan or health insurance coverage).

   To the extent a group health plan or health insurance issuer imposes a cumulative treatment limitation on a particular covered item or service (such as a limit on the number of items, days, units, visits or hours covered in a defined time period) independent of individual medical necessity determinations, the amount that has accrued toward the limit on the item or service (such as the number of items, days, units, visits or hours the participant, beneficiary or enrollee has used within that time period) it should be included.

2) *Billed charge*: The total charges for an item or service billed to a group health plan or health insurance issuer by a provider.

3) *Billing code.* The code used by a group health plan or health insurance issuer or provider to identify healthcare items or services for purposes of billing, adjudicating and paying claims for a covered item or service, including the CPT code, HCPCS code, DRG code, National Drug Code (NDC), or other common payer identifier.

4) *Bundled payment arrangement*: A payment model under which a provider is paid a single payment for all covered items and services provided to a participant, beneficiary or enrollee for a specific treatment or procedure.

5) *Copayment assistance*: The financial assistance a participant, beneficiary or enrollee receives from a prescription drug or medical supply manufacturer toward the purchase of a covered item or service.

6) *Cost-sharing liability.* The amount a participant, beneficiary or enrollee is responsible for paying for a covered item or service under the terms of the group health plan or health insurance

coverage. Cost-sharing liability generally includes deductibles, coinsurance and copayments, but does not include premiums, balance billing amounts by OON providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

7) *Cost-sharing information.* Information related to any expenditure required by or on behalf of a participant, beneficiary or enrollee with respect to healthcare benefits that are relevant to a determination of the participant's, beneficiary's or enrollee's cost-sharing liability for a particular covered item or service.

8) *Covered items or services.* Those items or services, including prescription drugs, the costs for which are payable, in whole or in part, under the terms of a group health plan or health insurance coverage.

9) *Derived amount*: The price that a group health plan or health insurance issuer assigns to an item or service for the purpose of internal accounting, reconciliation with providers or submitting data.

10) *Enrollee*: An individual who is covered under an individual health insurance policy as defined under section 2791(b)(5) of the Public Health Service Act.

11) *Historical net price*: The retrospective average amount a group health plan or health insurance issuer paid for a prescription drug, inclusive of any reasonably allocated rebates, discounts, chargebacks, fees and any additional price concessions received by the plan or issuer with respect to the prescription drug. The allocation shall be determined by dollar value for nonproduct specific and product-specific rebates, discounts, chargebacks, fees and other price concessions to the extent that the total amount of any such price concession is known to the group health plan or health insurance issuer at the time of publication of the historical net price in a machine-readable file. However, to the extent that the total amount of any non-product specific and product-specific rebates, discounts, chargebacks, fees or other price concessions is not known to the group health plan or health insurance issuer at the time of file publication, then the plan or issuer shall allocate such rebates, discounts, chargebacks, fees and other price concessions by using a good faith, reasonable estimate of the average price concessions based on the rebates, discounts, chargebacks, fees and other price concessions received over a time period prior to the current reporting period and of equal duration to the current reporting period.

12) *In-network provider:* Any provider of any item or service with which a group health plan or health insurance issuer, or a third party for the plan or issuer, has a contract setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary or enrollee.

13) *Items or services*: All encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment and fees (including facility fees), provided or assessed in connection with the provision of healthcare.

14) *Machine-readable file*: A digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost.

15) *National Drug Code*: The unique 10- or 11-digit 3-segment number assigned by the Food and Drug Administration, which provides a universal product identifier for drugs in the United States.

16) *Negotiated rate:* The amount a group health plan or health insurance issuer has contractually agreed to pay an in-network provider, including an in-network pharmacy or other prescription drug dispenser, for covered items and services, whether directly or indirectly, including through a third-party administrator or pharmacy benefit manager.

17) *Out-of-network (OON) allowed amount:* The maximum amount a group health plan or health insurance issuer will pay for a covered item or service furnished by an OON provider.

18) *Out-of-Network provider*: A provider of any item or service that does not have a contract under a participant's, beneficiary's or enrollee's group health plan or health insurance coverage to provide items or services.

19) *Out-of-pocket (OOP) limit*: The maximum amount that a participant, beneficiary or enrollee is required to pay during a coverage period for their share of the costs of covered items and services under their group health plan or health insurance coverage, including for self-only and other than self-only coverage, as applicable.

20) *Plain language:* Written and presented in a manner calculated to be understood by the average participant, beneficiary or enrollee.

21) *Prerequisite:* Concurrent review, prior authorization and step-therapy or fail-first protocols related to covered items and services that must be satisfied before a group health plan or health insurance issuer will cover the item or service. The term prerequisite does not include medical necessity determinations generally or other forms of medical management techniques.

22) *Underlying fee schedule rate*: The rate for a covered item or service from a particular in-network provider, or providers, that a group health plan or health insurance issuer uses to determine a participant's, beneficiary's or enrollee's cost-sharing liability for the item or service, when that rate is different from the negotiated rate or derived amount.