hfma
healthcare financial management association

HFMA Summary
Health Plan Price Transparency Requirements
Proposed Rule

Overview. On November 15, 2019, CMS issued a proposed rule that, if finalized, would require health plans to make an online price transparency tool that provides cost sharing and other information available to their members. The rule includes a request for information from stakeholders regarding including quality information with the out-of-pocket estimates provided by plans.

Plans are also required to make hardcopy out-of-pocket 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. Like the transparency rule finalized for providers, the proposed health plan rule also requires issuers to make a machine-readable file of their negotiated rates publicly available on the Internet. 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.

The rule modifies the medical loss ratio (MLR) calculation to allow plans to create benefit designs that reward members for choosing lower-cost providers.

Required data elements. 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). Key terms are defined in Appendix 1.

- *Out-of-pocket 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 spending incurred at the time a request for cost-sharing information is made, either with respect to a deductible or out-of-pocket limit.

- *Out of networ*k (OON). Allowed amount for the requested covered item or service, if the request for cost-sharing information is for a covered item or service furnished by an OON provider.

- *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.

- *Applicable notifications*. If applicable, the plan must make the following disclosures to its members:
    - OON providers may bill participants or beneficiaries for the difference between a provider's bill 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.

- 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.
- 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.
- 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 out-of-pocket spending estimates both in an online tool and in paper format. Below are specific details about each format.

Internet-based self-service tool. Under the Proposed Rule, 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.

- Covered item/service/procedure-specific. 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).

- 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 relevance. 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.

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Paper method. Information required under the proposed rule must be made available in plain language, without a fee, in paper form at the request of the participant or beneficiary (or his or her authorized representative). The group health plan or health insurance issuer is required to provide the same cost-sharing information as is provided online 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.

Public disclosure of in-network provider negotiated rates and OON allowed amounts for covered items and services. A group health plan or health insurance issuer must make designated information available on an Internet website in two machine-readable files.

- *Negotiated rate file*. This file must include all the following data elements:
    - Plan/employer identifier. The name and employer identification number (EIN) or Health Insurance Oversight System (HIOS) identifier, as applicable, for each plan option or coverage offered by a health insurance issuer or group health plan
    - Service identifier. A billing code or other code used by the group health plan or health insurance issuer to identify covered items or services for purposes of claims adjudication and payment, and a plain language description for each billing code
    - Negotiated rates. The rates must be reflected as dollar amounts, with respect to each covered item or service under the plan or coverage that is furnished by an in-network provider; associated with the National Provider Identifier (NPI) for each in-network provider; and associated with the last date of the contract term for each provider-specific negotiated rate that applies to each covered item or service, including rates for both individual items and services, and items and services in a bundled payment arrangement.

- *Out-of-network allowed amount file*. The OON file must include the following data elements:
    - Plan/employer identifier. The name and EIN or HIOS identifier, as applicable, for each plan option or coverage offered by a health insurance issuer or group health plan
    - Service identifier. A billing code or other code used by the group health plan or health insurance issuer to identify covered items or services for purposes of claims adjudication and payment, and a plain language description for each billing code
    - Unique OON allowed amounts. With respect to covered items or services furnished by OON providers during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file (except that a group health plan or health insurance issuer must omit such data in relation to a particular item or service and provider when compliance with this requirement would require the group health plan or health insurance issuer to report payment of OON allowed amounts in connection with fewer than 10 different claims for payments).
    - OON allowed amounts. The OON allowed amounts must be reflected as a dollar amount, with respect to each covered item or service under the plan or coverage that is furnished by an OON provider; and associated with the NPI for each OON provider.

- *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. HHS proposes to recognize the special circumstances of a different and newer type of plan for purposes of MLR reporting and calculations when that plan shares savings with consumers who choose lower-cost, higher-value providers.

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Appendix 1. Key Terms Defined in the Proposed Rule

1) *Accumulated amounts*. The amount of financial responsibility a participant or beneficiary has incurred at the time a request for cost-sharing information is made, either with respect to a deductible or out-of-pocket limit. If an individual is enrolled in other-than-self-only coverage, these accumulated amounts would include the financial responsibility a participant or beneficiary has incurred toward meeting his or her individual deductible and/or out-of-pocket limit, as well as the amount of financial responsibility that the individuals enrolled under the plan or coverage have incurred toward meeting the other-than-self-only deductible and/or out-of-pocket limit, as applicable. For this purpose, accumulated amounts include any expense that counts toward a deductible or out-of-pocket limit (such as a copayment or coinsurance), but excludes any expense that does not count toward a deductible or out-of-pocket limit (such as any premium payment, out-of-pocket 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 or beneficiary has used).

2) *Billing code.* The code used by a group health plan or health insurance issuer or its in-network providers 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 or other common payer identifier.

3) *Bundled payment.* A payment model under which a provider is paid a single payment for all covered items and services provided to a patient for a specific treatment or procedure.

4) *Cost-sharing liability.* The amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. This term generally includes deductibles, coinsurance and copayments, but it does not include premiums, balance billing amounts for OON providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

5) *Cost-sharing information.* Information related to any expenditure required by or on behalf of a participant or beneficiary with respect to healthcare benefits that are relevant to a determination of a participant's or beneficiary's out-of-pocket costs for a particular healthcare item or service.

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

7) *In-network provider.* A provider that is a member of the network of contracted providers established or recognized under a participant's or beneficiary's group health plan or health insurance coverage.

8) *Items or services.* All encounters, procedures, medical tests, supplies, drugs, durable medical equipment and fees (including facility fees), for which a provider charges a patient in connection with the provision of healthcare.

9) *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.

10) *Negotiated rate.* The amount a group health plan or health insurance issuer, or a third party on behalf of a group health plan or health insurance issuer, has contractually agreed to pay an in-network provider for covered items and services, pursuant to the terms of an agreement between the provider and the group health plan or health insurance issuer, or a third party on behalf of a group health plan or health insurance issuer.

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

12) *OON provider.* A provider that does not have a contract under a participant's or beneficiary's group health plan or health insurance coverage to provide items or services.

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

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

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