NEW TRANSPARENCY REQUIREMENTS FOR HEALTH PLANS

As benefits managers, you may have heard something about new transparency requirements that are going into effect soon for health plans. This briefing will outline those various legal requirements and the impact on your group health plans. This is the first of what will be a number of communications from us about the implementation of these new requirements as rules are clarified and finalized in the coming months.

THE LAWS

Two federal laws that have been finalized in the last year require greater transparency regarding the cost of certain prescription drugs and medical services.

A. The Transparency in Coverage Final Rule

On October 29, 2020, the U.S. Departments of Health and Human Services, Labor and the Treasury (together, the Departments) issued a final rule under the Patient Protection and Affordable Care Act (PPACA) and in furtherance of an executive order issued in 2019. This rule, entitled Transparency in Coverage, requires group health insurance carriers and self-insured plans to disclose rates and cost-sharing information for all covered items and services. The rule does not apply to Medicare, Medicaid, grandfathered health plans, standalone vision or dental plans, short-term limited duration plans, HRAs, FSAs or HSAs.

The disclosure obligations set forth in the rule are phased in over three years.

Effective January 1, 2022, group health carriers and self-insured plans must publicly disclose the following in three machine-readable files: (1) in-network provider negotiated rates, (2) out-of-network allowed amounts and billed charges, and (3) prescription drug negotiated rates and historical net pricing. These files must be posted prominently on a public website and be freely accessible. The files must be updated at least monthly thereafter.

Effective January 1, 2023, group health carriers and self-insured plans must provide cost-sharing information for 500 "shoppable services" (non-emergent services, which are to be defined by the Centers for Medicare and Medicaid Services CMS, that can be scheduled in advance such that a member can price-shop) to customers online. Papers copies must be made available upon request.

Effective January 1, 2024, the online cost-sharing information must include all covered items and services.

B. The Consolidated Appropriations Act, 2021 (CAA)

As 2020 drew to a close, Congress passed an omnibus spending measure which included a number of transparency provisions, including those set forth in the No Surprises Act.

i. CAA provisions

Effective December 27, 2021 and no later than June 1 of each year thereafter, carriers and self-funded plans must submit to the Departments certain information with respect to the plan or coverage for the previous plan year, including with respect to prescription drugs:

- The 50 most frequently dispensed brand prescription drugs and the total number of paid claims for each such drug
- The 50 most costly prescription drugs by total annual spending and the annual amount spent by the plan or coverage spent for each such drug
- The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report and, for each drug, the change in amounts expended by the plan or coverage in each such plan year
- Total spending by plan or coverage broken down by the type of health care services
- Spending on prescription drugs by the plan or coverage as well as by members
- The average monthly premiums paid by members and employers
- Rebates, fees and other renumeration paid by drug manufacturers to the plan, or its administrators or service providers, including the amount paid with respect to each therapeutic class of drugs and for each of the 25 drugs that yielded the highest amount of rebates
- Any reduction in premiums and out-of-pocket costs associated with these rebates

On June 23, 2021, the Departments issued a Request for Information on these CAA rules and is expected to issue proposed regulations by the end of the summer.

ii. No Surprises Act provisions

Effective January 1, 2022, the No Surprises Act requires the following of self-funded and fully insured health plans as pertains to transparency. These rules do not apply to pharmaceutical carve-out plans, as they are aimed at transparency in pricing regarding treatment at health care facilities.

- The plan must offer price comparison guidance by telephone and online which allows a plan member to compare the amount of cost-sharing that they would be responsible for paying to providers under the plan for a particular service.

- The plan must offer a database on a public website listing each provider or facility that has a direct or indirect contractual relationship with the plan.
- The plan must ensure provider directories are current and accurate with updates at least every 90 days.
- Health plans must provide an "Advanced Explanation of Benefits" to enrollees for scheduled services with a good faith estimate of the member's cost-sharing, among other information.
- Insurance cards must include in-network and out-of-network deductibles and out-of-pocket maximums.

NEXT STEPS

As of the time of this writing, the Departments are still in the process of seeking comment on the Transparency in Coverage rule and have just closed the comment period for the CAA Request for Information. Considering the administrative burdens these rules impose on plans, calls have been made for longer phase-in periods. In the meantime, we are in the process of seeking assurance from carriers for fully insured plans that they will be able to comply with these mandates on the timeframes set by the Departments. For our self-insured group health and pharmacy carve-out clients, we are gathering information from likely service providers. As regulations are finalized, we will be able to provide more information as to how we will be helping our self-funded clients to obtain the services that will be required under the new laws.