AAOS
American Association of Orthopaedic Surgeons

# Transparency in Coverage Final Rule Summary

***On October 29, 2020 the Departments of Health and Human Services, Treasury, and Labor released the Transparency in Coverage (CMS-9915-F) final rule. Below is a summary of the key changes which will be implemented:***

- The agencies write in the final rule that the Patient Protection and Affordable Care Act (PPACA) section 1131(e)(3) requires insurers to make public certain information to promote transparency in health care pricing (pg. 38)
- The agencies state that price transparency will allow consumers to make more informed health decisions, enable stakeholders' ability to support consumers in access to care, reduce the potential for surprise billing, increase competition while containing costs, and close the loop on price transparency efforts initiated in state and private markets
- The agencies claim that "the disclosures required under the final rules would also not constitute a breach or inducement of a breach of a duty to maintain secrecy, as the final rules apply prospectively in a regulatory environment in which all parties to provider agreements, and all affected plans and issuers, are being placed on notice and should be aware in advance of the requirements of the final rules. All parties to these contracts are therefore positioned to modify contractual arrangements, or similar policies, practices, or expectations relating to privacy or trade secrets to conform to the final rules. Otherwise, the final rules will supersede these arrangements to the extent necessary to implement these rules"

***Provisions***

- Requires group health plans and health insurance issuers in the individual and group market to disclose to participants, beneficiaries, or enrollees upon request, through a self-service tool made available by the plan or issuer on a website, the cost-sharing information for a covered item or service from a particular provider or providers
- Requires that plans and issuers also make such information available in paper form upon request
- Requires that the following seven content elements be disclosed: 1) estimate of the cost-sharing liability for the furnishing of a covered item or service by a particular provider or providers, including for bundled payments 2) accumulated amounts 3) in-network rates 4) out-of-network allowed amount 5) items and services content list 6) notice of prerequisites to coverage 7) disclosure notice
- The agencies state that the final rule is not intended to preempt state laws regarding balance billing
- The agencies state that the final rule does not apply to account-based group health plans, including Health Reimbursement Arrangements (HRAs), Health Flexible Spending Account (FSAs), or Qualified Small Employer Health Reimbursement Arrangement (QSEHRAs)
- All disclosures for transparency are subject to existing privacy laws, including HIPAA
- The agencies state that disclosing the in-network negotiated rates will allow employers to use network and benefit design tools to move participant and beneficiaries toward lower-priced providers and shift "from less favorable provider contracting models (such as discounted-charge contact, which can be vulnerable to

list-price inflation) to more favorable, alternative value-based contracting models (such as reference-based pricing and bundled payment arrangements)"

- **The agencies state that "while the departments address the problem of price transparency through this rulemaking, other government and industry stakeholders are working to address other issues highlighted by commenters, such as the availability of reliable quality data"**
    - The agencies suggest that third-party developers have access to quality data through NQF, AHRQ and others, and can independently combine price and quality information for consumers to use
    - *Note: In AAOS comments on the proposed rule, we stated that we support the disclosure of quality information alongside cost information. Consistent with our previous comments on regulatory relief, we encourage the agencies to make the format and type of quality reporting information consistent across plans and issuers.*
- States will be the primary enforcers of the requirements imposed upon health insurance issuers and plans or issuers will not have failed to comply should they act in good faith and with reasonable diligence to provide the required information

***Implementation Timeline***

- The rule will be implemented over three years
- Allowed amount files will include data for the 90-day period beginning 180 days before the file publication date
- The plan or issuer must update data in the machine-readable file monthly
- Beginning on or after January 1, 2022: Plans and issuers must disclose pricing information to the public through three machine-readable files
    - 1) disclosure of payment rates negotiated between plans or issuers and providers for all covered items and services
    - 2) disclosure of the unique amounts a plan or issuer allowed, as well as associated billed charges, for covered items and services furnished by out-of-network providers
    - 3) disclosure of prescription drug information
- Beginning on or after January 1, 2023: Plans and issuers must make cost-sharing information available for 500 items and services (See Table 1, pg. 94)
- Beginning on or after January 1, 2024: Plans and issuers must make cost-sharing information available for all items and services

***Definitions***

- In-network provider: any provider of items and services with which the plan or issuer, or a third-party for a plan or issuer, has a contract setting forth the terms under which a covered item or service may be provided to a participant, beneficiary, or enrollee (pg. 258)
- Negotiated rate: the amount a group health plan or health insurance issuer, or a third party on behalf of a plan or 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 plan or issuer, or a third-party on behalf of a plan or issuer

- Third-party: definition explicitly includes third-party administrator or pharmacy benefit manager
- 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 plan, including deductible, coinsurance, and copayments but excludes premiums or any applicable balance billing amounts
- Accumulated amounts: amount of financial responsibility that a participant, beneficiary, or enrollee has incurred at the time the request for cost-sharing information is made, with respect to a deductible and/or an out-of-pocket limit
- In-network rates: as applicable to the plan's or issuer's payment model—negotiated rate and underlying fee schedule rate, reflected as dollar amounts as well as the underlying fee schedule rate used to determine the participant, beneficiary, or enrollee cost-sharing liability only where that rate is different from the negotiated rate
    - The negotiated rate must always be disclosed with cost-sharing liability estimates, even if it is not used to determine the cost sharing
- Items and services content list: apply only when a participant, beneficiary, or enrollee requests cost-sharing information for an item or service that is subject to a bundled payment arrangement that includes multiple items or services
    - Items and services in a bundled payment arrangement would need to be disclosed individually, but cost-sharing liability would be estimated based on the bundled price
- Notice of prerequisites to coverage: a notification, whenever applicable, informing the individual that a specific covered item or service for which the individual requests cost-sharing information may be subject to a prerequisite for coverage
    - Prerequisite is defined as certain requirements related to the medical management techniques (concurrent review, prior authorization, and step-therapy or fail-first protocols) for covered items and services that must be satisfied before a plan or issuer will cover the item or service
- Disclosure notice: communicates certain information in plain language, including the follow specific disclosures
    - A statement that out-of-network providers may bill participants, beneficiaries, or enrollees for the difference between providers' billed charges and the sum of the amount collected from the group health or health insurance issuer and the amount collected from the participant, beneficiary, or enrollee in the form of cost-sharing
    - Notice be required to convey that actual charges for the participant's, beneficiary's, or enrollee's covered items and services may be different from those described in a cost-sharing liability estimate
    - Include a statement that the estimated cost-sharing liability for a covered item or service is not a guarantee that coverage will be provided for those items and services

- Plans and issuers be permitted to include any additional information, including other disclaimers that the plan or issuer determines appropriate, so long as the additional information does not conflict with information they are required to provide

***Specific Content Elements***

- Content elements specific to the in-network rate and allowed amount file: employer identification number (EIN) or health insurance oversight system (HIOS) ID; billing codes (CPT, HCPCS, DRG, NDC) or other common payer identifier code; in-network applicable amounts; out-network allowed amounts; or negotiated rates and historical net prices for prescription drugs; place of service code

***Use of Premium Revenue under the Medical Loss Ratio***

- HHS is updating 45 CFR 158.221(b)(9) to allow shared savings payments derived from price transparency to be included in the medical loss ratio numerator
- This ensures that issuers would not be required to pay medical loss ratio rebates based on plan designs that would provide benefits to consumers that are not currently captured in existing medical loss ratio revenue or expense categories (pg. 333)

*Read the complete rule here.*

*Read AAOS comments on the proposed rule here.*