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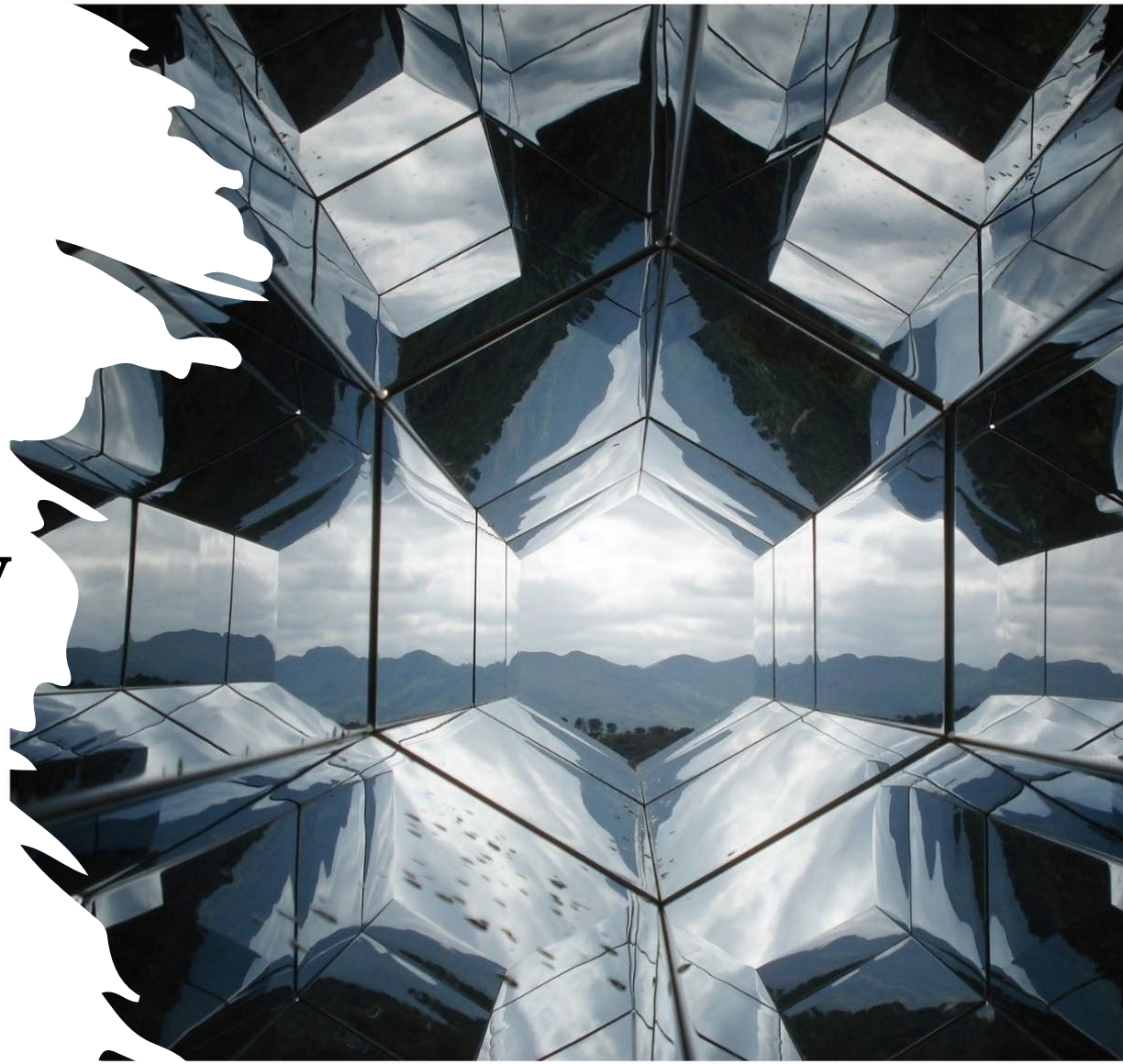

Through the Looking Glass: Overview of The New Transparency Rules Applicable to Group Health Plans

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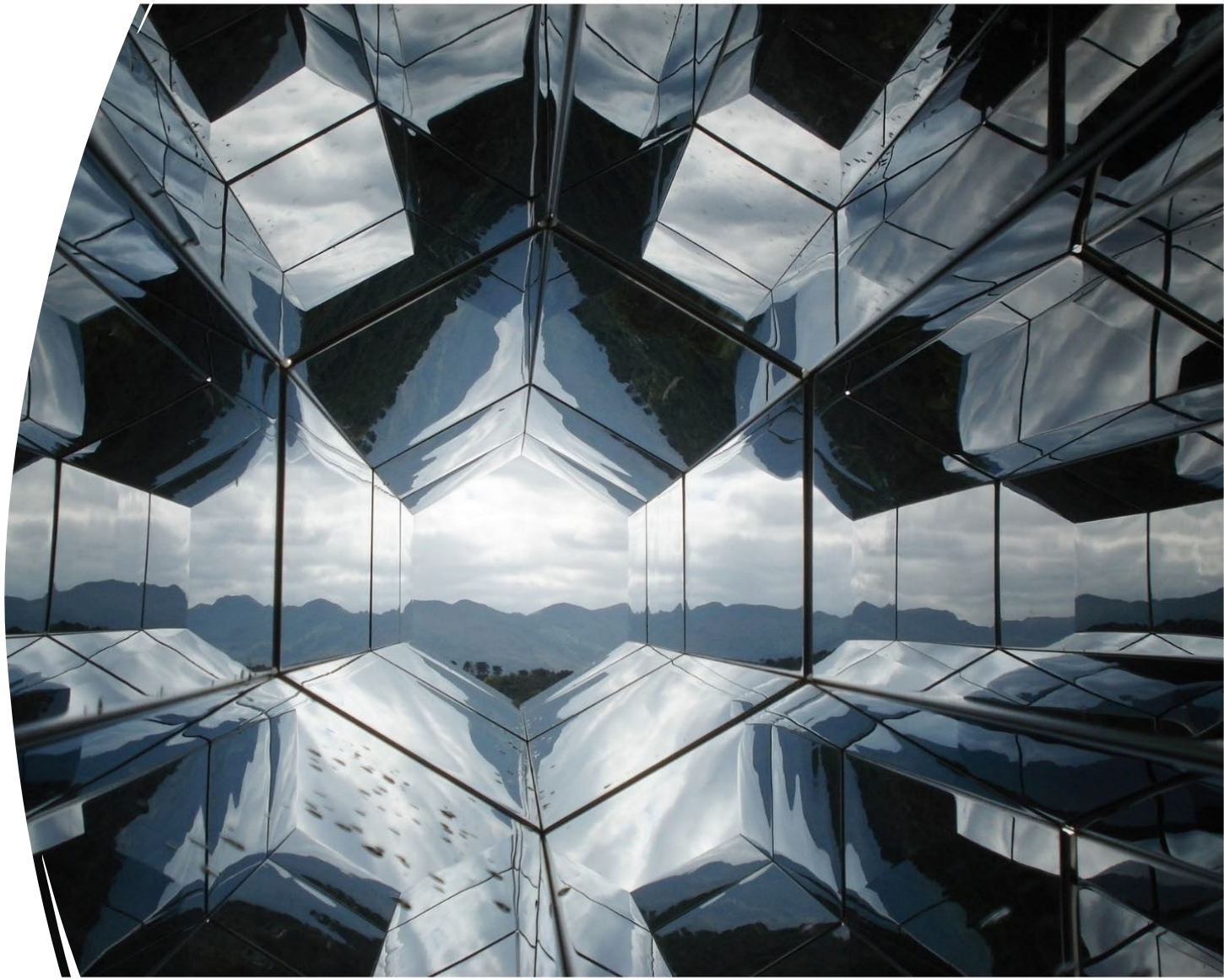
Agenda

- Overview of Transparency in Coverage Final Rule
- Disclosure Requirements included in the Consolidation Appropriations Act, 2021
- Roles and Responsibilities?
- Effective Date
- Next Steps
- Q&A



Overview of Transparency in Coverage Final Rule

Background of Transparency in Coverage Final Rule ("Final Rule")

- Section ACA 1311(e)(3) transparency reporting requirements provide broad authority to the Departments to require health insurance issuers and health plans to make eight specific categories of information listed in the statute publicly available as well as "other information" determined by the Secretary
- On June 24, 2019, Executive Order 13877 ("EO") titled "Improving Price and Quality Transparency in Healthcare To Put Patients First" was issued to address transparency in quality and health care price
- The EO directed federal agencies to adopt rules, issue guidance, and develop reports to increase transparency of health care price and quality information

Overview of Transparency in Coverage Final Rule cont.

- **Specifically, the EO included the following initiatives:**
  - ❑ directed the Secretary of Health and Human Services (HHS) to propose regulations requiring hospitals to disclose standard charge information, including negotiated rates and prices of shoppable items and services between insurers and health care providers ("Hospital Transparency Rule");
  - ❑ required the Secretaries of HHS, Treasury, and Labor (jointly the "Departments") to issue proposed rules for healthcare providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care; and
  - ❑ instructed the HHS Secretary, in consultation with the Attorney General and the Federal Trade Commission (FTC), to issue a report describing the ways the federal government or the private sector are impeding healthcare price and quality transparency for patients, provide recommendations for eliminating the barriers, and promote competition

Overview of Transparency in Coverage Final Rule cont.

- On November 19, 2019, the Departments released the proposed "Transparency in Coverage" Rule and on October 29, 2020, the Departments released the Final Rule.
- The Final Rule requires most non-grandfathered group health plans and health insurance carriers comply with the following:

  - ❑ **Participant Disclosures upon request**
    - Group health plans and insurers must provide participants with advanced, personalized cost-sharing information, including an estimate of the individual's-out-of-pocket cost and negotiated rates, for covered healthcare items, services, and prescription drugs through an internet-based self-service tool.
    - Participants include beneficiaries, enrollees and/ or their authorized representative.
    - The Final Rule also clarifies that disclosures of "cost-sharing information" are only required for individuals who are enrolled in the plan. No disclosures are required to be made to a "participant" or "beneficiary" solely because they might become eligible for the plan in the future.

Overview of Transparency in Coverage Final Rule cont.

<u>Specific Information required in Participant disclosures:</u>

- Estimated cost-sharing liability for a covered service
  - ❑ Amount a plan participant is responsible for paying for a covered service by a particular provider under the terms of the plan (e.g., deductibles, co-insurance, co-payments)
  - ❑ Balanced billing for out-of-network providers or the cost of non-covered expenses are excluded from this requirement
- Accumulated amounts
  - ❑ Amount a plan participant has paid towards the plan's deductible and/or out-of-pocket maximum
  - ❑ Amounts accrued toward any cumulative treatment limit (e.g. number of physical therapy visits used compared to the maximum number of visits permitted under the plan terms
- In-Network (negotiated) rate for covered expenses
  - ❑ negotiated rate" as the amount a plan or issuer has contractually agreed to pay for a covered item or service, whether directly or indirectly through a third-party administrator (TPA) or PBM, to an in-network provider, including an in-network pharmacy or other prescription drug dispenser, for covered items or services
- Out-of-Network allowed amounts
  - ❑ Maximum amount a plan or insurer would pay for the requested item or service provided by an out-of-network provider

Overview of Transparency in Coverage Final Rule cont.

Specific Information required in Participant disclosures cont.

- List of items and services subject to bundled payment arrangements
  - ❑ Bundled payment arrangement occurs when providers and/or healthcare facilities are paid a single payment for all the services performed to treat a patient undergoing a specific episode of care. An "episode of care" is the care delivery process for a certain condition or care delivered within a defined period of time (i.e., value-based arrangements)
  - ❑ Must disclose a list of each covered item and service and the cost-sharing liability for the bundle (but not each item or service)
- Notice of Prerequisites
  - Concurrent review, prior authorization, step-therapy or fail first-protocols that must be satisfied before the service is covered
- Disclosure Notice advising of potential balance billing by out-of-network providers

Overview of Transparency in Coverage Final Rule cont.

- **Public Disclosures**
  - Make available three different "machine-readable files" to the public that include:
    - negotiated rates for all covered items and services with in-network providers and the plan;
    - historical payments to (allowed amounts), and billed charges from, out-of-network providers; and
    - in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.
  - The data must be provided in a standard format and made available to the public for plan years beginning on or after January 1, 2022
  - Expands upon price transparency rule applicable to hospitals that became effective on January 1, 2021

Overview of Transparency in Coverage Final Rule cont.

- **Medical Loss Ratio Calculation (MLR Rebate)**
  - Under the ACA, health insurers that fail to spend a certain amount on healthcare claims or quality improvement expenses are required to provide a MLR rebate to the Plan (e.g., employers and employees).
  - Under the Final Rule, insurers providing plans that encourage participants to shop for lower-cost, higher-value providers will be eligible to take a credit for "shared savings" in the MLR calculation when it results in savings.
  - Insurers can claim these "shared savings" beginning with the 2020 MLR reporting year (for reports filed by January 31, 2021).
  - The Final Rule does not include a definition of "shared savings" or "lower-cost, higher-value". HHS has deferred to state regulators to define permissible shared-saving plan design and applicable criteria necessary to identify "lower-cost, higher-value" providers.

Overview of Transparency in Coverage Final Rule cont.

Enforcement

- All plans subject to §2715 of the Patient Health Services Act ("PHSA") must comply with the Final Rule
- There is no exemption for governmental plans or church plans
- State insurance regulators will regulate enforcement of the transparency rule for fully insured plans
- The Department of Labor will regulate group plans subject to ERISA (self-insured, level funded)
- The Treasury will regulate church plans
- HHS will regulate non-Federal governmental plans

Penalties

- Final Rule fails to address penalties for noncompliance
- Under the ACA and PHSA, the penalty for failure to comply is a $100 a day per violation for each affected individual

Disclosure Requirements included in the Consolidation Appropriations Act, 2021

- The Consolidated Appropriations Act, 2021("CAA") signed into law on December 27, 2020, contains several provisions enhancing transparency in group health plans

- The new transparency and disclosure requirements include:
  - ❑ broker and consultant fee disclosures
  - ❑ an advanced explanation of benefits before scheduled care, including information such as the estimates of cost-sharing and the amount the plan will pay for the service and whether the provider is in-network or OON
  - ❑ price comparison tools available online and over the phone
  - ❑ up-to-date provider directories
  - ❑ inclusion of in-network and out-of-network deductibles and out-of-pocket maximums on health plan member electronic or physical identification cards
  - ❑ out-of-network providers to provide a "good faith estimated amount" for all services to be provided
  - ❑ Reporting on pharmacy Benefits and Drug Costs

Disclosure Requirements included in the Consolidation Appropriations Act, 2021 cont.

Broker and consultant fee disclosures

- Amends ERISA Section 408(b)(2) to add additional requirements for "covered service providers" related to fee disclosures to the plan fiduciary of **group health plans**
  - ❑ The disclosures must be made for the contract with the covered service provider to be deemed "reasonable" under ERISA and therefore exempt from the prohibited transaction rules
  - ❑ Group health plans will be required to disclose the compensation paid to any broker or consultant that receives $1,000 or more
  - ❑ The disclosures to the plan fiduciary include a description of the services provided and a description of all covered compensation (direct and indirect)
- **Covered Service providers**
  - ❑ brokerage services and consulting
  - ❑ Brokerage services include recordkeeping services, benefits administration, stop-loss insurance, PBM services, transparency tools and vendors, and TPAs. This is not an exhaustive list.
  - ❑ Additional guidance is needed on the definition of "consulting". It is unclear if it includes "advising on the selection of service providers such as a TPA or PBM or whether it applies when they "consult" on a specific plan design. This could potentially include TPAs, Stop-Loss Carrier, Pharmacy, PBMs, wellness vendors, etc.

Disclosure Requirements included in the Consolidation Appropriations Act, 2021 cont.

Broker and consultant fee disclosures cont.

- Covered plans includes "group health plans" as defined under ERISA
  - ❑ Medical plans, dental plans, vision plans, health FSAs, onsite clinics, HRAs,
  - ❑ Group term life, accidental death and dismemberment insurance, and long-short term disability insurance, or an HSA account are not group health plans under ERISA

- **Timing of the Disclosure**
  - ❑ A disclosure is required regardless of whether services are performed, or the compensation is received by the broker and/or consultant, its affiliate, or subcontractor
  - ❑ Disclosures must be made to the responsible plan fiduciary "reasonably in advance" of the date of entering into, extending, or renewing any contract or arrangement
    - Contracts entered into before December 27, 2021, are not subject to the new requirements until a renewal or extension of the contract occurs
  - ❑ Changes to the disclosed information must be provided as soon as practicable, but not later than 60 days from the date the change occurred, or the broker and/or consultant is informed of the change

Disclosure Requirements included in the Consolidation Appropriations Act, 2021 cont.

Broker and consultant fee disclosures cont.

- **Violations**
  - ❑ Upon discovery of a violation, the plan fiduciary is required to take the following actions to avoid a prohibited transaction:
    - Request in writing that the broker or consultant make a full disclosure
    - If the broker or consultant fails to comply or does not respond within 90 days, the plan fiduciary should notify the DOL in accordance with the provisions under ERISA Section 408(b)(2) within 30 days following the earlier of the refusal to comply or the lapse of the 90-day response period
    - Plan fiduciaries should review ERISA's fiduciary prudence standards for guidance on how to handle disclosure failures

Disclosure Requirements included in the Consolidation Appropriations Act, 2021 cont.

Reporting requirements related to prescription drug benefits and costs

- Group health plans are required to report the following information to the Departments:
  - ❑ The plan year, number of enrollees, and each state in which the plan is offered
  - ❑ The top 50 brand name prescription drugs paid for by the plan, and the total number of paid claims for each such drug
  - ❑ The top 50 most expensive prescription drugs paid for by the plan by total annual spending, and the annual amount spent by the plan for each such drug
  - ❑ The 50 prescription drugs with the greatest increase in plan expenditures since the prior plan year, and the change in amounts spent for each drug
  - ❑ The total spending on health care services by plan, broken down into specific categories, including hospital costs, primary care costs, specialty care costs, and prescription drug costs
  - ❑ Average monthly premiums paid by employers and by participants
  - ❑ The impact of on premiums by rebates and fees paid by drug manufacturers to the plan or its administrators or service providers, including any reduction in premiums and out-of-network pocket costs associated with the rebates and fees.
- The first report is due one year after enactment of the CAA with subsequent reports due June 1 of each year thereafter

Roles and Responsibilities?

- Health insurers are responsible for compliance on fully-insured plans
- Self-funded plan sponsors are responsible for compliance
  - ❑ May contract with third-party services to provide the required information
  - ❑ Review indemnification and other standard of care provisions included in the services agreement to ensure it adequately protects the plan in case the third-party service provider does not completely fulfill its obligations

Effective Dates

December 27, 2021

- ❑ Broker and Consultant Fee Disclosures
- ❑ Prescription drug benefits and cost reports (June 1 thereafter)

Effective for Plan Years on or after January 1, 2022:

- ❑ Public disclosures of negotiated and historical pricing information (Refer to slide no. 8)
- ❑ Group health plan disclosures required under CAA (refer to slide no. 11)

Effective for Plan Years on or after January 1, 2023:

- ❑ 1st phase of Participant disclosures required under the Final Rule
- ❑ 500 items and services identified in the preamble of the Final Rule must be made available for searching in the online tool

Effective for Plan Years on or after January 1, 2024:

- ❑ 2nd phase of Participant disclosures required under the Final Rule
- ❑ All remaining covered items and services must be available for searching in the online tool

Next Steps

Employer Actions

- Fully insured employers should contract with their carrier to provide the required disclosures to the public and to plan participants
- Self-insured employers should contract with their TPA (or other third party) to provide the required disclosures and should be sure to include any necessary contractual language to limit their liability if the third party fails to provide the disclosures
- Monitor for potential litigation or a delay in the rules
- ACA Decision pending in the Supreme Court could impact validity of Final Rule

Q&A

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