Transparency in Coverage Rule

SUMMARY AND FAQ

Overview

On October 29, 2020, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury jointly released the Transparency in Coverage final rule. The rule requires group health plans and issuers offering coverage in the group and individual markets make available to the public, through regularly updated machine-readable files, (1) in-network negotiated rates with providers, (2) historical payments to out-of-network providers and their billed charges, and (3) in-network rates and historical net prices for covered prescription drugs (Public Access Requirement). Group health plans and issuers must also develop online price transparency tools to give consumers personalized cost-sharing information (Cost-Sharing Information Requirement).

The rule adopts a phased-in approach with multiple effective dates:

I. Public Access Requirement

The Public Access Requirement goes into effect for plan years (policy years in the individual market) beginning on or after January 1, 2022. Group Health plans and issuers must make three separate machine-readable files publicly available. The files must be updated monthly and include the following detailed pricing information:

a) In-network: Negotiated rates for all covered items and services between the plan or issuer and in-network providers.
b) Out of network: Historical payments to, and billed charges from, out-of-network providers.
c) Prescription drugs: In-network negotiated rates and historical net prices for all covered prescription drugs at the pharmacy location level.

II. The Cost-Sharing Information Requirement

Make available personalized out-of-pocket cost information, and the underlying negotiated rates, for services through an internet-based self-service tool and in paper form upon request. The Cost-Sharing Information Requirement goes into effect for plan (or policy) years beginning on or after:

a) January 1, 2023 for estimates concerning 500 specific items and services; and
b) January 1, 2024 for estimates on all items and services covered by the plan.

General Questions

Is this part of President Trump's Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First?	The Executive Order is not a rule or law itself, but requests agency rulemaking to fulfill the goals it describes. In this case, the departments were directed to issue rulemaking on health care price and quality transparency which they did in the form of the Transparency in Coverage Final Rule. Information regarding other transparency legislation can be found here.
Which health plans are subject to the Transparency in Coverage rule requirements?	Health Insurance Issuers—Group Market Y Health Insurance Issuers—Individual Market Y Qualified Health Plan (QHP) Issuers Y

	Insured and Self-Funded Group Health Plans (ERISA, Non-Federal Gov Plans, Church Plans) Y Federal Employees Health Benefit Plan (FEP) Y Grandfathered Health Plans N Short term, limited duration coverage N Personal Funding Accounts (FSA, HRA, etc.) N Medicare Advantage N Medicare Supplement N Medicaid MCO N Vision-only plans N Dental-only plans N
What does the Transparency in Coverage regulation mean for all parties?	This regulation establishes price transparency requirements for group health plans and health insurance issuers in the individual and group markets for the timely disclosure of information about costs related to covered items and services under a plan or health insurance coverage. The final rule clarifies that disclosures of cost-sharing information (required beginning in 2023) are only required to individuals who are enrolled in the plan or coverage; no disclosures are required to be made to a 'participant' or 'beneficiary' solely because they might become eligible for the plan in the future. (This does not apply to the MRF portion of the ruling.)
What is a "machine readable file" (MRF)? Will the file in a format that is accessible and readable by people as well?	A machine-readable file (MRF) is 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. The purpose of these files is to provide raw data in a specific format that can be read by machines without requiring manipulation or other human intervention. These files are not intended to be user friendly or easily understood by the average consumer. Future implementations under the Cost-Sharing Information Requirement include member-facing tools and information.
Will members need to log in to view these files?	No. This information must (1) be posted on a publicly accessible website, (2) be free of charge, and (3) not require an account or any personal identifying information.
Can the data format for the publicly published INN file be the same as that for the file transmitted to the association, or are the requirements separate?	The Association will provide a standardized template to support file sharing between home and host plans. Premera will publish the file in a non-proprietary, open format,

Sales Questions

How does Premera plan to support self-funded and Optiflex clients regarding the new requirements?	Premera has a standard process for implementing all new laws that impact us and our customers. Implementation efforts have begun, and we have a company-wide, cross functional team working as part of an implementation project to ensure we are in compliance with all aspects of the new requirements. In order to both meet the minimum requirements of the regulation and be in good partnership with our self-funded clients (including Optiflex), Premera will aggregate both insured and self-funded data into the required 3 machine readable files and post publicly on Premera.com. Premera will not support benefit carve outs, such as pharmacy, or publish associated data in our files. Please note decisions are subject to any future guidance from the federal government that we may receive.
Does the MRF file need to be customized to each SF account?	The files must include certain data points that are unique to each group, such as their Employer Identification Number (EIN). However, we do not believe a separate file is required for each employer group. This is subject to change upon receipt of further federal guidance.
Does each SF account need to publicly post the MRF on their employer website, or can they point the to the health plan website?	Both methods are permitted, however we have made a business decision to post the files to our website at Premera.com
Are there any Transparency related provisions/ requirements that will require our benefit booklets to be updated?	In general, Premera will update fully-insured benefit booklets, as needed. For self-funded groups, if Premera produces their benefit booklets, they need to let Premera know if they would like updates made after consulting their own counsel.
Are there any Transparency related provisions/ requirements that will require updates to the contracts between Premera and self-funded groups?	The expectation is that contracts between Premera and self-funded groups will need to be updated.

Producer/Employer

What is the employer's responsibility?	Employer responsibility is to ensure that their employees have access to the data and that the files are published on a public website- either health plan or employer site.

What information does a group need and where will they go to get it?	Insurers and self-funded group health plans will be responsible for providing three separate machine-readable files to include: 1. INN negotiated rates 2. OON historical paid amounts 3. RX contracted prices Premera is required to post the required data for fully-insured business, and will include self-funded data as a courtesy to our self-funded groups, including Optiflex. As per the final rule this information will be made available to the public on Premera.com. Premera will not support benefit carve outs, such as pharmacy, or publish associated data in our files. Groups with carved out benefits will need to work with their vendors to comply.
What is the producer's responsibility?	The mandate does not make specific reference to Producer responsibilities. The mandate does make specific references to the health plan and/or the employer responsibilities for meeting the requirements of the mandate.

Provider

Where is this data coming from?	Each of the machine-readable files will source data and include the following: a) In-network: Negotiated rates for all covered items and services between the plan or issuer and in-network providers. The rate data will come from provider contracts with Premera. b) Out of network: Historical payments to, and billed charges from, out-of-network providers. This information will be sourced from our claims processing system. c) Prescription drugs: In-network negotiated rates and historical net prices for all covered prescription drugs at the pharmacy location level. Data will be provided by our pharmacy benefit manager (PBM) Express Scripts (ESI).
Is there anything that the provider will need to do?	The mandate does not make specific reference to Provider responsibilities. The mandate does make specific references to the health plan and/or the employer responsibilities for meeting the requirements of the mandate.
Does this impact any confidentiality provisions in our provider contracts?	No. Our provider contracts have compliance with law provisions that supersede provisions prohibiting the sharing of terms in provider agreements.