July 1 Deadline Looming for Health Plan Transparency Rules

Insights
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In late 2020, the Departments of Health and Human Services, Labor, and Treasury (the Departments) released Transparency in Coverage (TiC) rules that put several new compliance burdens on group health plan sponsors. The next item plan sponsors must address will be making public disclosures regarding in-network and out-of-network rates beginning July 1, 2022. To meet that deadline, plan sponsors should be working with carriers and third-party administrators (TPA) to ensure they have the necessary information in the proper format to comply with the new rules.

Mind the Specifics

The TiC rules originally required certain employers to provide "machine readable files" (MRF) revealing in-network rates, out-of-network charges and information relating to prescription drug coverage and costs by January 1, 2022. In 2021, the Departments delayed prescription drug disclosure enforcement indefinitely pending forthcoming regulations. On the other hand, the Departments only pushed the other disclosure deadline six months. So, plans should be well under way in ensuring they can publish the mandatory general in-network negotiated rates and out-of-network allowed amounts by July 1.

The first MRF must disclose a plan's negotiated rates for covered items and services for all in-network providers. The second MRF must show the historical payments and billed charges from out-of-network providers. This file should include at least 20 historical entries to help protect individual participant privacy.

Machine-Readable Files

The MRF must include:

- For each group medical plan option, either the insurer Health Insurance Oversight (HIOS) identifier or, if none, the employer identification number (EIN).
- A billing code (e.g., Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-related Group (DRG) code, National Drug Code (NDC), or any other common payer identifier, as well as a plain language description for each billing code.

In-Network Rates

The In-Network Rate MRF must show:

- In-network rates for each item or service provided by in-network providers, including any negotiated rates, fee schedule rates used to determine cost-sharing, or derived amounts, whichever rate is applicable to the plan.
- If a rate is percentage-based, include the calculated dollar amount, or the calculated dollar amount for each National Provider Identifier (NPI)-identified provider, if rates differ by providers or tiers. Bundled items and services must be identified by relevant code.

Allowed Amounts

The Allowed Amount MRF must show:

- Out-of-network allowed amounts and billed charges with respect to covered items or services, furnished by out-of-network providers during the 90-day period starting 180 days prior to the MRF publication date.
- The plan must omit data for a particular item or service and provider when the plan or insurer would be reporting on payment of out-of-network allowed amounts for fewer than 20 different claims for payment under a single plan or coverage. These amounts must also be expressed as dollar amounts and associated with the NPI, Taxpayer Identification Number, and Place of Service Code for each network provider.

Content Guidance

On April 19, 2022, the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments) issued FAQ guidance to clarify that where a plan or issuer agrees to pay an in-network provider a percentage of billed charges and cannot assign a dollar amount prior to a bill being generated, plans and issuers may report a percentage number, rather than a dollar amount.

The FAQs further provide that where the TiC Final Rules reporting method does not support an alternative reimbursement arrangement, or where an arrangement requires submitting other information to describe the nature of the negotiated rate, plans and issuers may disclose in an open text field a description of the formula, variables, methodology, or other information necessary to understand the arrangement.

Next Steps

Plan sponsors must update the MRFs at least monthly. So, they should establish processes to coordinate regularly with the carrier in an insured plan and with the TPA in a self-funded plan.

The Departments will require the files to be posted to a public website that consumers can use without providing individually identifiable information. The website cannot require passwords, account setup, login credentials or any other barriers to accessing the required information.

The TiC rules allow plan sponsors to contract with a carrier, TPA, or other third party to produce and house the information for a plan. However, plans should be aware that they might ultimately remain responsible for any failures.

A carrier will be responsible for any MRF failure as long as it is required in writing to ensure a plan's compliance. Self-funded plans also can contract to have a third party provide and update MRF, but the TiC rules do not shift liability to a third party for self-insured plan failures. Thus, self-funded plans should carefully review indemnification provisions in all relevant vendor service agreements.

Most carriers and TPAs have already contacted employer plan sponsors offering to assist with preparing, updating, and hosting the MRF. Employers should be carefully reviewing their service agreements and related contracts to make certain they include specific provisions dealing with all aspects of the required disclosures.

Conclusion

We will continue to monitor the guidance we expect to be coming soon as to certain administrative requirements regarding formatting and hosting of the required forms. We will provide updates as needed. Make sure you are subscribed to Fisher Phillips' Insight system to get the most up-to-date information. If you have questions, contact your Fisher Phillips attorney, the author of this Insight, or any attorney in our Employee Benefits and Tax Practice Group.

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