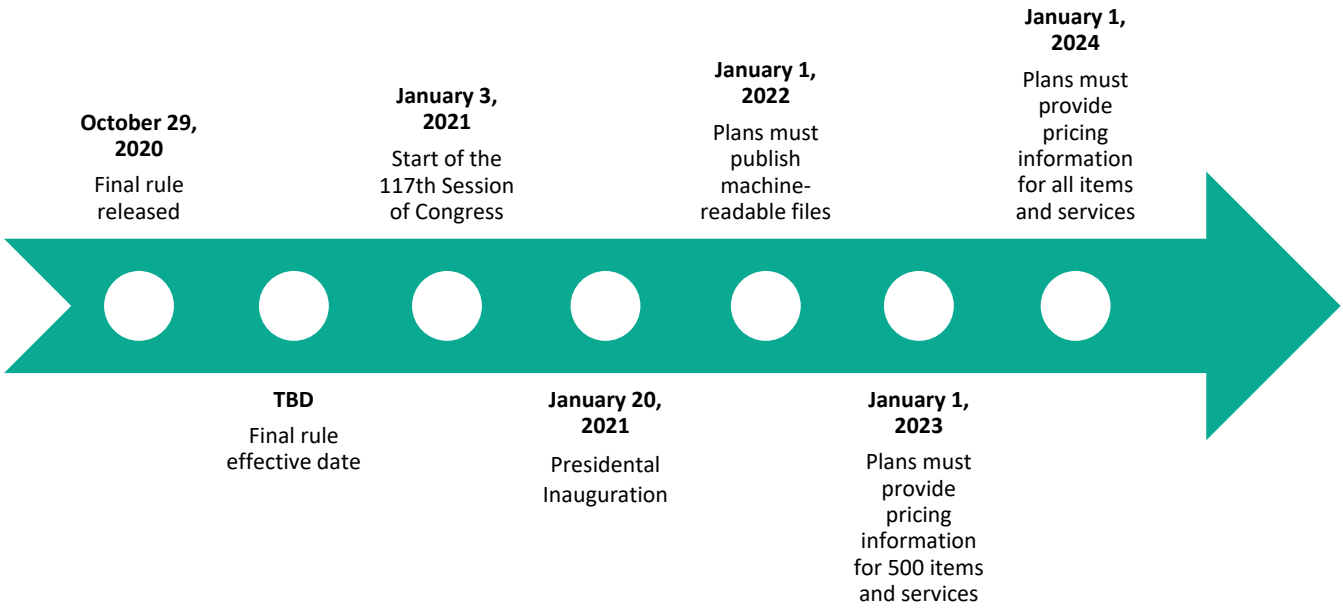
Policy Update

TRANSPARENCY IN COVERAGE FINAL RULE

OVERVIEW

On October 29, 2020, the US Department of Health and Human Services (HHS), along with the US Departments of Labor and the Treasury, finalized the rule Transparency in Coverage. This rule stems from President Trump's Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First. The final rule puts forth requirements for group health plans and issuers on the individual and group markets to disclose cost-sharing information, in-network provider negotiated rates, historical out-of-network allowed amounts, and drug pricing information. This rule does not apply to grandfathered health plans, excepted benefits plans, healthcare sharing ministries or short-term limited duration insurance plans. A similar rule requiring hospitals to publish price information was finalized in 2019 and is set to take effect January 1, 2021, although it remains subject to ongoing litigation.

TIMELINE OF TRANSPARENCY REQUIREMENTS IMPLEMENTATION



TRANSPARENCY PROVISIONS

The final rule includes provisions requiring plans and issuers to publicly disclose information relating to rates, cost-sharing and drug pricing information. The rule implements these transparency measures over a three-year phase-in, new from the proposed rule. Beginning January 1, 2022, plans and issuers must disclose in-network provider negotiated rates, historical out-of-network allowed amounts, and pricing information for prescription drugs through three machine-readable files. The machine-readable files are intended for researchers, legislators and regulators, as well as application developers that could make the information usable and easily understood by the general public.

Beginning January 1, 2023, plans and issuers must make cost-sharing information available for 500 items and services identified by HHS, and beginning January 1, 2024, plans and issuers must make cost-sharing information available for all items and services.

In promulgating the final rule, HHS broadened the originally proposed disclosure obligations by requiring disclosure of "negotiated rates" even when they are irrelevant for determining member cost-sharing, such as in the case of capitated or other value-based arrangements with providers. HHS declined to create any exception to the reporting requirements in connection with bundled, capitated, reference-based or other alternative payment models, except when the issuer does not have any negotiated rates or underlying fee schedule rates that it can report. HHS noted that additional technical guidance, which apparently will not be subject to public notice and comment procedures, will be made available on GitHub, where issuers will be able to "collaborate with the Department in real-time."

MEDICAL LOSS RATIO CALCULATION

The final rule also makes changes to the commercial market medical loss ratio calculations, which limit the portion of premium dollars that health insurers may spend on administration, marketing and profits. The Affordable Care Act requires that most commercial insurance companies spend at least 80% (in the individual and small group markets) or 85% (in the large group market) of premium income on clinical services and quality improvement activities, and the remaining 15% to 20% (as applicable) on administration, marketing and profit.

Under the final rule, HHS would allow plans that provide shared savings to consumers who choose "lower-cost, higher-value providers" to take credit for such shared savings in the numerator of the issuers' medical loss ratio. In other words, the plan may treat the member payment as equivalent to an incurred medical expense or quality improvement activity cost, although HHS clarified that it considers shared savings payments to reflect a separate (third) category of expenses.

The final rule offers no definition of "shared savings" or "lower-cost, higher-value," which are subject to a range of different interpretations, particularly with regard to defining and measuring "value." HHS deferred to state regulators to define permissible shared savings models and develop any applicable criteria for the identification of "lower-cost, higher-value" providers. Depending on the degree to which state regulators promulgate new requirements in this area, new state-by-state regulations could create operational challenges for plans that would base shared savings on a cost and quality evaluation framework that already exists (or is in development) at a national level. Some insurers already offer member shared savings arrangements designed to drive provider choice, but further incentivizing the use of these tools may accelerate consumer-directed healthcare strategies in both the payer and provider markets.

Using financial incentives to drive members to lower-cost providers could also have unintended consequences in the provider market. For example, some academic medical centers may have higher costs due to investments in medical education, research initiatives, and provision of specialized and tertiary services. “Lower-cost, higher-value” networks can be designed to avoid or mitigate these types of issues. For example, some insurers have developed tiered hospital networks that separately evaluate academic medical centers and community hospitals.

By incentivizing insurers to adopt new shared savings arrangements against a backdrop of potential state-by-state regulation, the final rule may also create new opportunities for healthcare technology, analytics and quality monitoring companies that promise to simplify cost and quality analyses for payers. There may also be interest in creating greater standardization in these assessments, which would decrease operational burdens and costs on providers.

FINAL RULE OUTLOOK

While both Republicans and Democrats support increasing transparency and arming consumers with information to make better healthcare choices, the fate of this particular rule and its requirements remain unclear. Many health plans have already sharply criticized the rule, and the outcome of this week’s presidential election may affect the future of this policy.

Like other transparency rules before it, this rule will almost certainly face legal challenges. The rule itself seems to anticipate this fate, defending against potential the First Amendment challenges and proactively addressing severability issues.

Hospitals have brought forward similar legal arguments regarding transparency requirements, challenging a related final rule that would require disclosure of their standard charges, including payer-specific negotiated rates. In June 2020, the US District Court for the District of Columbia upheld the hospital reporting rule in response to a challenge intended to stop its implementation. However, the decision was appealed to the US Court of Appeals for the District of Columbia Circuit, which heard oral arguments in the case in October 2020. The hospital rule is slated to take effect January 1, 2021, but could be delayed or revised depending on the outcome of the election or a ruling against HHS.

Although Democrats in general favor transparency provisions, a Democratically controlled Congress or a new Biden Administration could invalidate or delay implementation of the health plan and hospital transparency rules. Specifically, Congress could act via the Congressional Review Act (CRA). Enacted in 1996, the CRA empowers Congress to invalidate regulations and regulatory guidance issued by executive branch agencies within 60 days of receiving the final rule. The CRA creates a mechanism, called a joint resolution of disapproval, by which Congress may nullify an agency finalized rule. However, should President Trump be re-elected or the Senate remain in control of Republicans, it is unlikely that the CRA would be utilized to review this regulation. Instead, stakeholders would have to work with Congress to address the rule legislatively.