Guidance
Compliance
Confidence

Society of Professional Benefit Administrators

ADVANCING SELF-FUNDED HEALTHCARE

spbatpa.org

SPBA

Transparency Summit

- **Session 1, March 18: 3 Machine-readable files**
- **Session 2, March 25: Advanced Explanation of Benefits**
- **Session 3, April 22: Price/Cost comparison tool**

SPBA

New Payer Requirements effective January 1, 2022

NSA = No Surprises Act
TiC = Transparency in Coverage Rule

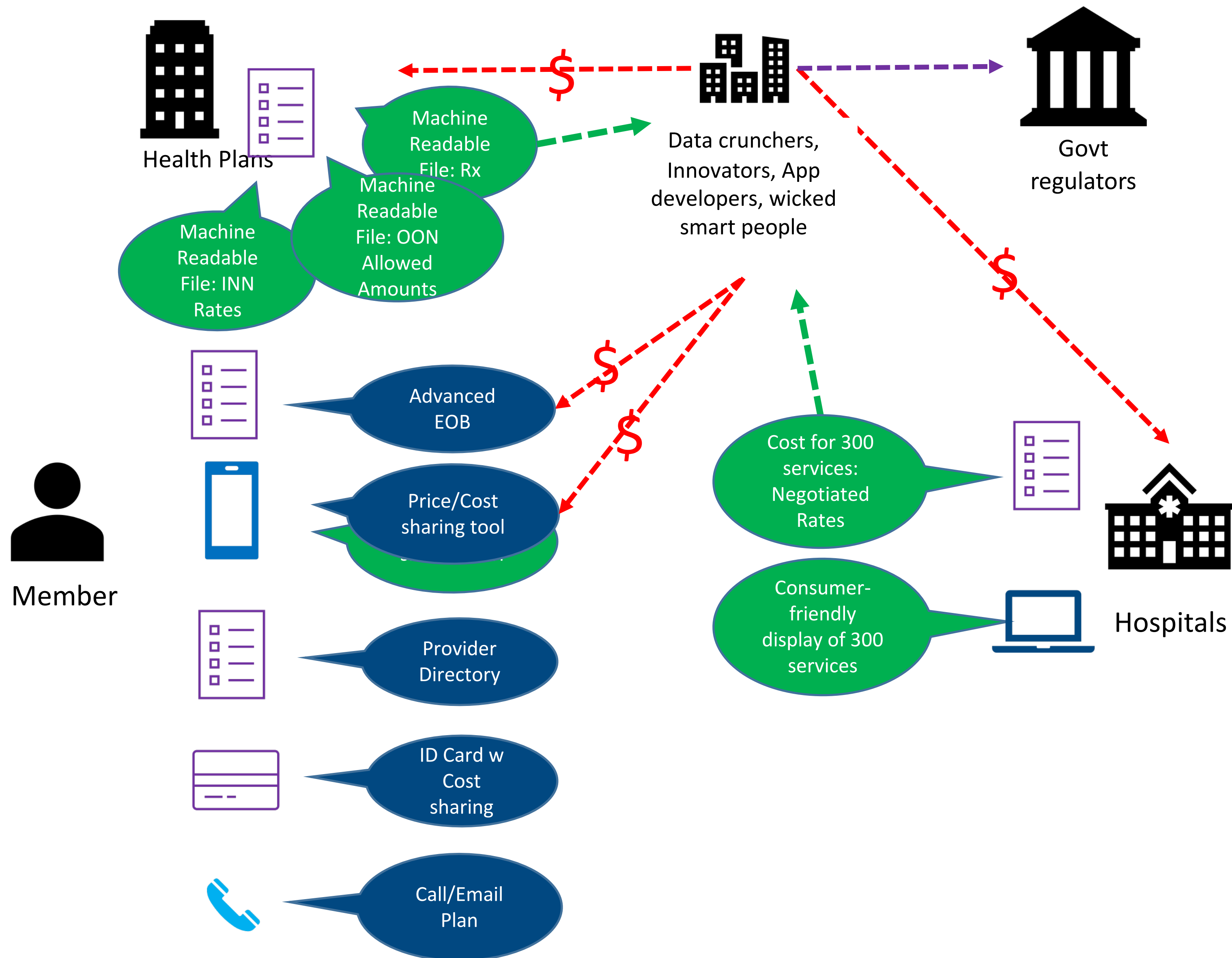
Surprise Balance Billing (OON Claims)

- **NSA: Reimbursement, Settlement, and Independent Dispute Resolution process** for 3 OON situations:
  - All OON emergencies
  - OON nonemergency items and service in INN facility
  - All air ambulance
- **NSA: Members cost-sharing** in 3 OON situations based on median in-network rate

Transparency (All claims)

- **TiC: 3 publicly available machine-readable files (MRF):**
  - INN rates
  - OON Allowed amounts – actual 3-month average amounts from six month look back
  - Rx rates
- **NSA: Advanced EOB for all scheduled services**: Provider sends cost estimate to plan, plan sends A+EOB to member within 1-3 days
- **NSA and TiC: Price transparency tool:** Maintain price comparison web tool and phone line for patients to compare providers and services
- **NSA: Provider directories:** Validate and update directory no less than every 90 days and manage patient requests
- **NSA: Insurance cards:** Include deductible, out-of-pocket max limit, and phone / website for INN providers

Transparency Rule/No Surprises Act: Combined Transparency Requirements



= Transp Rule requirements

= No Surprises Act requirements

- The Transparency Rule (TiC) and No Surprises Act (NSA) require a number of transparency provisions, both industry facing and consumer facing, for both health plans and hospitals
- The transparency requirements of the NSA and TiC are not related to the surprise balance billing provisions; they are broadly applicable
- The expectation is that innovators, app developers and government regulations will use the public data and develop new pricing products, strategies and policies

SPBA Transparency Summit

Session I: Machine Readable Files

Transparency Rule: In-Network file and Allowed Amount MRFs

Effective 1/1/2022

In-network machine-readable public file

- For each coverage option offered by a plan or issuer:
  - Name and the 14-digit HIOS identifier; OR
  - (if HIOS 14-digit ID is not available) the 5-ditit HIOS identifier; OR
  - (if no HIOS ID is available) the EIN;
- A billing code and plan language description for each billing code for each item/service under each coverage option;
- All applicable rates, which may include one or more of the following:
  - Negotiated rates,
  - Underlying fee schedules, OR
  - Derived amounts.
- Applicable rates, including bundled payment arrangements, must be:
  - Reflected as dollar amounts.
  - Associated with the NPI, TIN, AND Place of Service Code
  - Associated with the last date of the contract term or expiration date for each provider-specific rate; AND
  - Indicated with a notation where reimbursement arrangement other than standard fee-for-service model applies (ex: capitation, bundled payment).

Allowed amount (OON) machine-readable public file

- For each coverage option offered by a plan or issuer:
  - Name and the 14-digit HIOS identifier; OR
  - (if HIOS 14-digit ID is not available) the 5-ditit HIOS identifier; OR
  - (if no HIOS ID is available) the EIN;
- A billing code and plan language description for each billing code for each item/service under each coverage option;
- Unique OON allowed amounts and billed charges for covered items/services, furnished by the OON providers during the 90-day time period that begins 180 days prior to the publication date of the file.
- Each unique OON allowed amount…
  - Must be reflected as a dollar amount;
  - Must be associated with the NPI, TIN and Place of Service Code for each OON provider
- Exception: If there are fewer than 20 claims for the item/service under a single plan or coverage, payer should not report. Possibility to aggregate data when using a 3rd party.

Transparency Rule: Prescription Drug pricing MRFs
Effective 1/1/2022

- For each coverage option offered by a plan or issuer:
  - Name and the 14-digit HIOS identifier; OR
  - (if HIOS 14-digit ID is not available) the 5-ditit HIOS identifier; OR
  - (if no HIOS ID is available) the EIN;

- The NDC and the proprietary and nonproprietary name assigned to the NDC by the FDA for each coverage option offered by the plan or issuer;

- Negotiated rates which must be:
  - Reflected as dollar amounts, with respect to each NDC
  - Associated with the NPI, TIN, AND Place of Service Code
  - Associated with the last date of the contract term or expiration date for each provider-specific rate; AND

- Historical net prices that are:
  - Reflected as dollar amount, with respect to each NDC
  - Associated with the NPI, TIN, AND Place of Service Code
  - Associated with the 90-day time period that begins 180 days prior to the publication date of the machine-readable file for each provider-specific historical net price that applies to each NDC (except when less than 20 different claims)

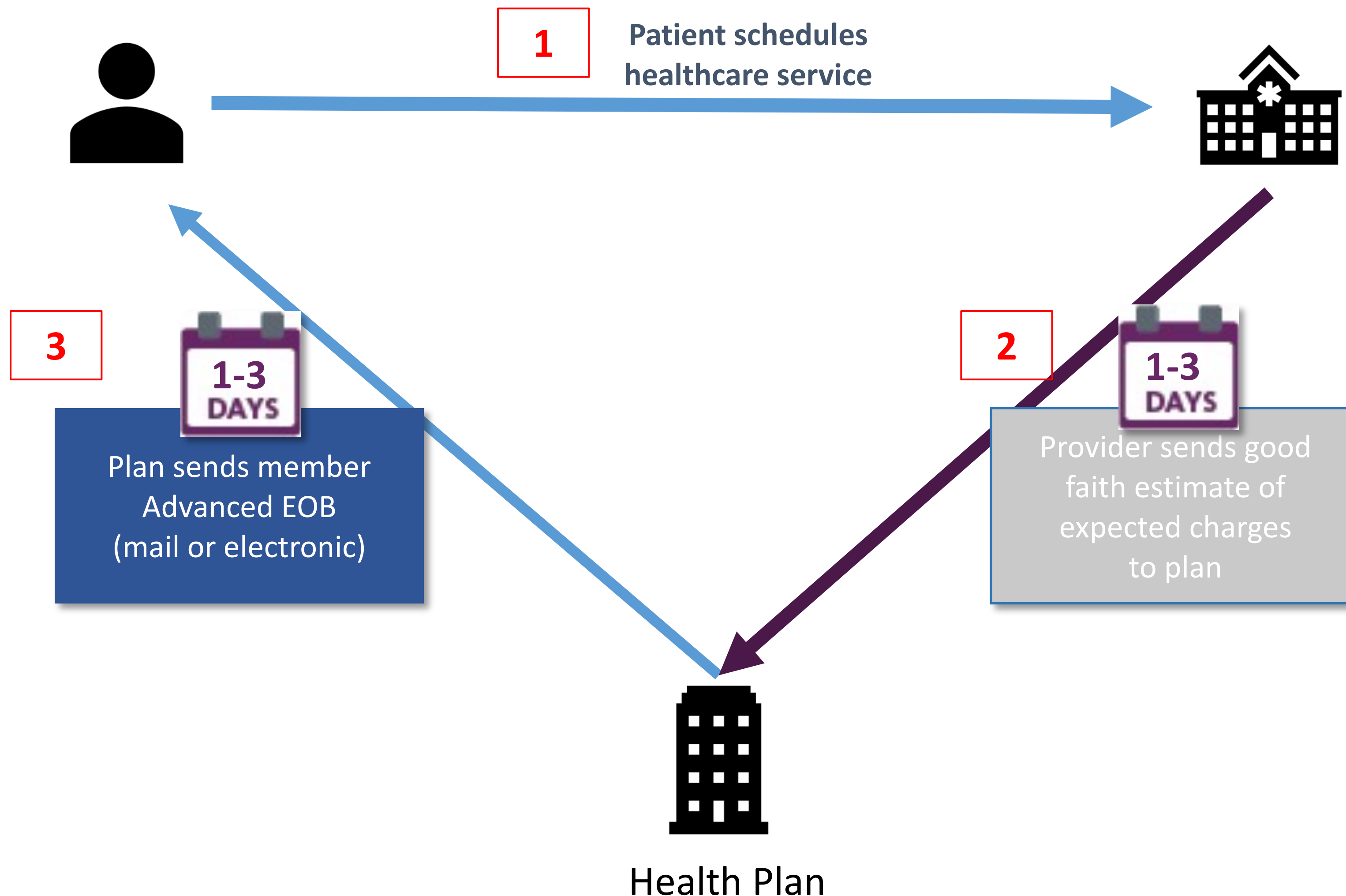
Machine Readable Files (MRFs): Discussion Questions

- Do plans have all necessary data in-house?
  - For In-Network File?
  - For Allowed Amount File?
  - For Rx File?
  - If not, where do plans need to get the data? (vendors, hospital MRFs)
  - Any communications from vendors, PBMs?
  - Contract changes with vendors for data?
- Once you have the data, how easy to update monthly?
- Rules give examples, but do not define format of MRFs. Suggestions on format types?

SPBA Transparency Summit

Session II: Advanced EOB

No Surprises Act Transparency: Advanced Explanation of Benefits



- - Applies to all services provided by providers and facilities, not just out-of-network
- - Applies whenever an appointment is made for services
- - Advanced EOB includes:
  - - Whether provider/facility is in- or out-of-network
  - - Where to find INN
  - - Provider's estimate of services and contracted rate
  - - Cost sharing estimate; amount incurred toward deductible, OOP maximums
  - Disclaimers

Advanced Explanation of Benefits (AEOB)
Effective 1/1/2022

All providers must ask all patients with scheduled services if they are enrolled in health insurance. ALL providers (INN and OON) <u>must then provide the patient's payer</u> with a good faith estimate of the cost of items and services.

- Good faith estimate must be sent by provider one day after service is scheduled and at least 3 business days before the appointment OR, if service is scheduled at least 10 business days in advance, not later than 3 business days after scheduling.*

Within 1 business day of receiving the above good faith estimate from the provider (or within 3 days of receipt of estimate if service is scheduled at least 10 business days in advance*), payer provides the member with an Advanced Explanation of Benefits – through mail or electronic means as requested by the member- that includes:

- Whether the provider or facility is a participating provider (INN), and the contracted rate for the item or service;
- If the provider or facility is OON, description on how patient can find information on INN providers;
- The good faith estimate sent by the provider;
- A good faith estimate of the amount the payer is responsible for paying;
- A good faith estimate of the amount of any cost-sharing for with patient will be responsible;
- A good faith estimate of the amount the patient has incurred toward meeting deductibles and OOP maximums;
- A disclaimer that coverage is subject to medical management, if applicable;
- Any other info or disclaimer as applicable.

**HHS may change the timelines in this section through regulation.*

Advanced Explanation of Benefits: Discussion Questions

- Communication from provider to health plan on “good faith” estimate of charges: How to receive this communication?
  - Existing paper or electronic streams or transactions (prior auth, eligibility (270)) or new avenues?
- Data for AEOB: Is it available? Where does it come from? Folded into existing processes?
- Communication from health plan to member:
  - How to send – existing routes, paper or electronic or both?
- How specific an estimate? Especially with the OON.
- Are these timelines doable? (1 day after receipt of provider’s estimate)
- Would you want to add information?
- What questions/recommendations do we have for regulators?
- Downstream: Will members actually look at AEOB? If so, what would be consequences? How could health plan strategically use the AEOB? (Steerage to or away from certain providers, etc.)

SPBA Transparency Summit

Session III: Price Comparison/Cost Sharing Tool

No Surprises Act compared to Transparency: Price/Cost Sharing Tool

Price/Cost Sharing Comparison Tool	**No Surprises Act** Price/Cost Sharing Tool Effective: January 2022	**Transparency in Coverage Rule** Price/Cost Sharing Tool Effective: January 2023 (500 services)
Method	Tool on website	"internet-based" and paper/mail
At patient's request		*
Member financials		
Estimated cost sharing/financial responsibility		
Accumulated amount for deductible, OOP limit		
Compare/Search by:		
Specific items and services		
Provider name if in network		
Billing codes		
Plan Year		
Geographic Region		
Dosage		
General amount of cost sharing		
Pricing		
In-network contracted rate or underlying fee schedule as $ amount		
Out of network allowed amount, as $ amount or %		
Other		
Various notices		

Price Comparison/Cost Sharing tool: Discussion Questions

- Do plans have similar tools already?
- Do plans have ability or prefer to build internally or outsource?
- Is the data available? (Consider data already gathered for MRFs and Advanced EOB)
- Is the requirement to have both paper and electronic difficult?
- What questions/recommendations do we have for regulators?
- Downstream: Given Advanced EOB, the price/cost tool, the MRFs, and the prohibition on surprise balance billing, what trends might we see with networks and providers?