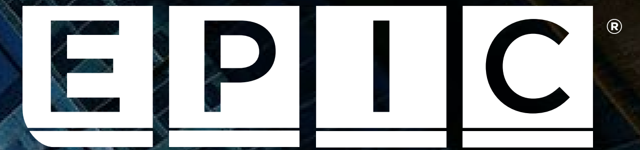

Update on Transparency, Surprise Billing & Rx/Health Cost Reporting Requirements

Compliance Series

September 15, 2022

EPICBROKERS.COM

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Presenters

Liz Mann, J.D. Director of Compliance - EPIC
Liz Mann is EPIC's internal compliance director. Liz and her team are responsible for disseminating information to clients about changing requirements and regulations and reviewing all plan designs and programs for compliance with Federal and State regulations. Liz is embedded into our account management team to provide timely support and guidance as ERISA-related regulations or concerns emerge in the marketplace. As a client, you have the option of directly accessing Liz or accessing her traditionally through your account team. Liz graduated Magna Cum Laude from Saint Mary's College in Notre Dame, IN with Bachelor of Arts degrees in History and French. She graduated with her law degree from University of Toledo, College of Law in Toledo Ohio in 2007. She has accumulated over 14 years of experience working in employee benefits and offers expertise in ERISA, IRS, COBRA, FMLA and ACA compliance.

David Flotten, J.D. Senior Compliance Consultant – Benefit Comply David has over 24 years' experience in employee benefits and employment law. David regularly presents on employee benefits compliance and other HR topics, including for the College of Continuing & Professional Studies at the University of Minnesota. He has also taught the PHR/SPHR and SHRM-CP/SHRM-SCP exam prep courses. Prior to joining Benefit Comply, David served as Sr. Compliance and Workplace Solutions Consultant at USI Insurance Services and as Sr. Compliance Consultant for Associated Benefits & Risk consulting. Before entering the employee benefits field, David worked at a private law practice and in the Minnesota court system. David received his law degree, magna cum laude, from the University of Minnesota Law School and his Bachelor of Arts degree from Gustavus Adolphus College. He is also a member of the Society of Human Resources Managers (SHRM).

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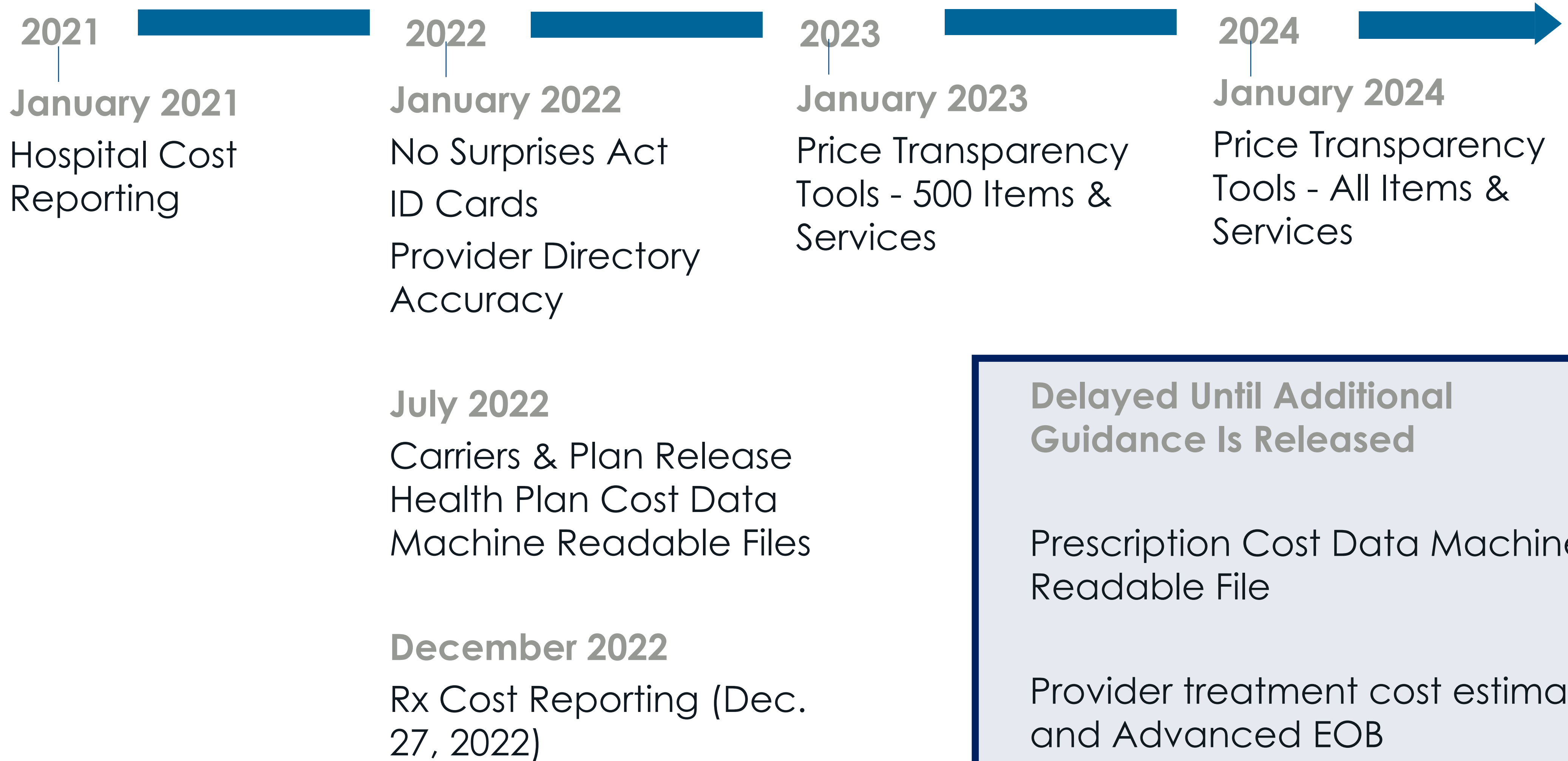
Health Cost
Transparency

Health Cost Transparency Timeline



Hospital Cost Reporting

- Things We Have Learned from the Hospital Cost Reporting Data

New York Times
Hospitals and Insurers Didn’t Want You to See These Prices. Here’s Why.
Aug. 22, 2021
https://www.nytimes.com/interactive/2021/08/22/upshot/hospital-prices.html

Hospital Cost Reporting

EPIC

- Differences Between Different Payers

Why Hospitals and Health Insur

https://www.nytimes.com/interactive/2021/08/22/u

90%

The New York Times

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The price for an **M.R.I.**
at Mass General is ...

$1,019	$3,101	$3,809
with a Cigna plan.	with an Aetna plan.	with a Humana plan.

Special offer. Subscribe for ~~$4.25~~ $1 a week.

EXPAND

Hospital Cost Reporting

- Difference Between Insurance and Medicare Price

At Memorial Regional Hospital, in Florida, an **M.R.I.** costs ...

$1,827

with a Cigna plan.

$2,148

with a Humana plan.

$2,455

with a Blue Cross plan.

$262

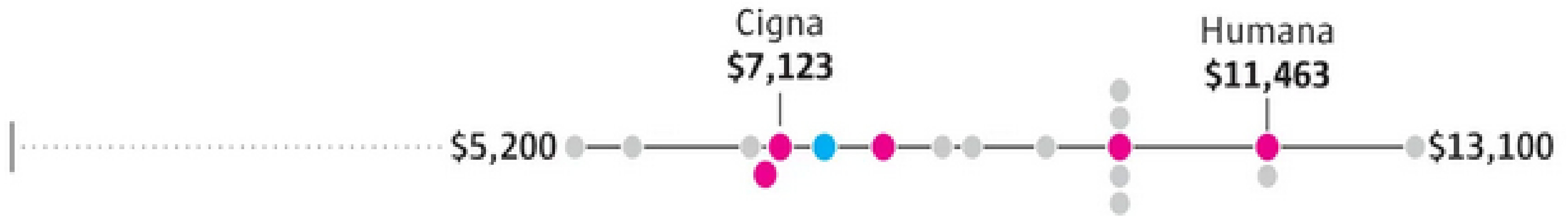
with a Medicare plan.

Hospital Cost Reporting

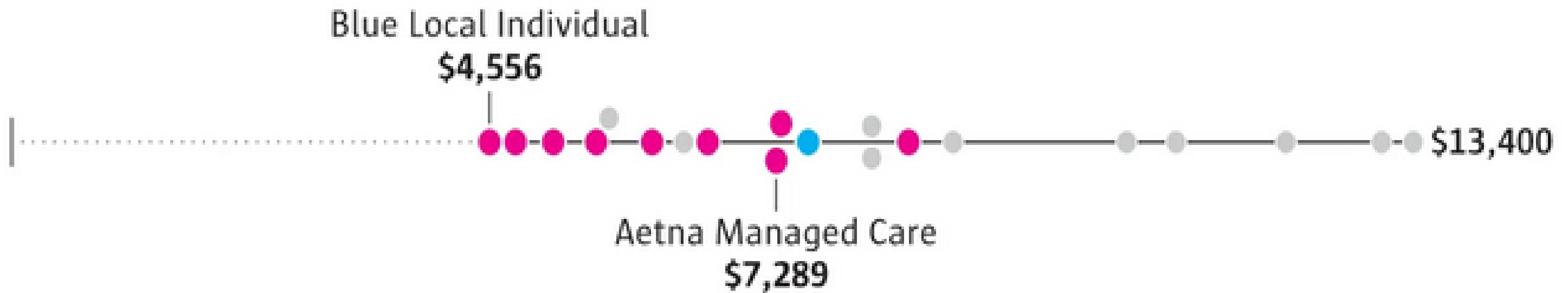
RABIES SHOT PRICE FOR: ● major insurers ● other insurers ● paying cash

Intermountain
Murray, Utah

UF Health Shands Gainesville, Fla.



Wake Forest Baptist Winston-Salem, N.C.



Hospital Cost Reporting

EPIC

- Same Insurer, Different Plans

At Aurora St. Luke's in Milwaukee, an **M.R.I.** costs United enrollees ...

$1,093

if they have United's HMO plan.

$4,029

if they have United's PPO plan.

No Surprises Act

Out of Network Emergency Services

Out of Network Air Ambulance Services

Non-Emergency Services by Out of Network Providers at In Network Facilities

No Surprises Act

EPIC

Out of Network Emergency Services

- No prior authorization (even out of network)
- Services must be covered regardless of whether provider is in-network or out-of-network or any other exclusions in the plan
- Participant cost sharing can be no higher that in-network cost sharing and must be counted against in-network deductibles and out of pocket maximum
- Provider cannot balance bill the participant for amounts in excess of cost sharing
- Amount the plan must pay the provider determined by state law (if any); amount the plan and provider agree to; or independent dispute resolution process.

No Surprises Act

EPIC

Out of Network Air Ambulance Services

- Out-of-network services must be covered if they would have been covered by an in-network provider
- Participant cost sharing can be no higher that in-network cost sharing and must be counted against in-network deductibles and out of pocket maximum
- Provider cannot balance bill the participant for amounts in excess of cost sharing
- Amount the plan must pay the provider determined by state law (if any); amount the plan and provider agree to; or independent dispute resolution process.

No Surprises Act

EPIC

Non-Emergency Services by Out of Network Provider at In Network Facility

- Participant cost sharing can be no higher that in-network cost sharing and must be counted against in-network deductibles and out of pocket maximum
- Provider cannot balance bill the participant for amounts in excess of cost sharing
- Amount the plan must pay the provider determined by state law (if any); amount the plan and provider agree to; or independent dispute resolution process.
- Out of network provider can avoid requirements of No Surprises Act if they obtain participant consent to provide such treatment after providing a notice with certain specified criteria.

Machine Readable Files

EPIC

- Pricing Data Disclosure – The Machine-Readable Files
  - Effective July 1, 2022 - Plans & insurers must publicly post machine-readable cost files and update monthly
  - The In-Network Rate File
    - All applicable rates with in-network providers for all covered items and services (including negotiated rates, underlying fee schedules, or derived amounts)
  - The Allowed Amount File
    - One on billed charges and allowed amounts for out-of-network providers
  - The Prescription Drug File - Enforcement delayed indefinitely
- Do employers need to post a link?
  - Departments (DOL, IRS, HHS) Guidance Released August 19th
  - Employers do not need to post link to files on the employer's company website
  - Posting only required if employer maintains a **public** website for the employer's group health plan
  - Most employers do not maintain a public website for their plan.
  - An intranet site available only to employees or participants is not a public website.

Price Transparency Tools

EPIC

- Health plans must offer internet based self-service tool by which participant can obtain individualized cost sharing estimate of services at both in-network and out-of-network facilities.
  - Tool for 500 specified shoppable services must be available for plan years starting on or after January 1, 2023
  - Tool for all other services must be available for plan years starting on or after January 1, 2024
- Tool must disclose
  - Participant's estimated cost sharing liability for covered item or service
  - Participants accumulated deductible and out of pocket amounts at the time of the request
  - In network rates for the covered item or service
  - Out-of-network allowed amounts
  - Items and services included in a bundled payment arrangement
  - Notice of any prerequisites to coverage (e.g. prior authorization, fail first protocols, step therapy, etc.)
  - Miscellaneous standard disclosure items
- Participants may also request paper disclosure.
- Self-funded employers will be dependent on TPA to create and maintain tool – make sure this is included in contracts with TPAs.

Mental Health Parity Disclosures

- Plan administrator must disclose criteria used for making medical necessity determinations for mental health and substance abuse disorder benefit upon request by participant or in-network provider.
  - Medical necessity criteria for both medical/surgical and mental health/substance use benefits that demonstrate medical necessity determination for mental health/substance abuse not more restrictive than medical/surgical
  - Processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation, e.g. satisfaction of "fail first protocol" before approval of certain treatment options
- For fully insured plans, primary responsibility for providing the disclosure falls on the carrier.
- Self-funded employer will have to rely on TPA to help them create the disclosure.
  - Create in advance or wait for request?
  - Only have 30 days to respond when a request comes in – is that enough time to create a mental health parity disclosure from scratch, especially if plan has employer-specific or customized mental health/substance absence or medical/surgical coverage?
  - EPIC has a partnership with Self Insured Reporting, a third-party vendor that will provide the analysis at special partner pricing for EPIC clients. For more information on EPIC's solution reach out to your EPIC representative.

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Rx Reporting

Background

As part of the Consolidated Appropriations Act of 2021, (CAA) employer-sponsored plans must submit certain data about prescription drug and healthcare spending annually to CMS, called the Prescription Drug Data Collection Reporting (RxDC). Interim Final Rules were released in November 2021.

Goal

- To collect information on drug costs for the federal government to create an annual report on prescription drugs and eventually lower drug costs

Instructions

- In June 2022, the Departments released updated reporting instructions and reporting templates

Background

EPIC

Covered Plans

All fully insured and self-funded group health plans must submit the RxDC reporting. This includes:

- Non-ERISA health plans (church and government plans)
- Small employers
- Grandfathered plans
- Excepted Benefits, Spending Accounts and Medicare/Medicaid are **excluded**

Deadline

The first report is due December 27, 2022, for reference years 2020 and 2021

- The reference year is the calendar year of data that is submitted in the report
- Starting in 2023, reports will be due annually on June 1

Register with HIOS

EPIC

HIOS System

Reporting entities must be registered with HIOS

- Register on the CMS Enterprise Portal
- Only entities submitting information need to register with HIOS
  - It can take up to two weeks to complete the registration process

RxDC Reporting Module

Submit data through the RxDC reporting module

- Plans may rely on third party administrators (TPAs), pharmacy benefit managers (PBMs) or other third parties to report on their behalf
  - An entity that submits some or all the required information is called a "reporting entity"
- Multiple vendors may report for the same employer
  - Vendors should not report duplicate information
- Files must be submitted in CSV format in the CMS templates found in the Enterprise Portal

Submit One Plan File

EPIC

Plan Files

- P1: individual and student market plan list
- P2: group health plan list*
- P3: federal employee health benefit plan (FEHP) list

*P2 is the plan list all EPIC clients will report

Submit One Plan File

P2: Group Health Plan List

- Number of members as of 12/31
- Market segment
- State where coverage is offered
- Issuer Name & EIN
- TPA Name & EIN
- PBM Name & EIN
- HIOS Plan ID (if applicable)
- Group health plan name and ID number
- ERISA plan number (Form 5500 plan number)
- Plan Sponsor Name & EIN

Submit Eight Data Files

EPIC

Data Files

- D1: Premium and Life-Years
- D2: Spending by Category
- D3: Top 50 Most Frequent Brand Drugs
- D4:Top 50 Most Costly Drugs
- D5: Top 50 Drugs by Spending Increase
- D6: Rx Totals
- D7: Rx Rebates by Therapeutic Class
- D8: Rx Rebates for the Top 25 Drugs

CMS is encouraging reporting entity PBMs, TPAs, and Carriers to submit aggregate data rather than plan specific data. Please check with your reporting entity to determine if they are submitting plan specific data or aggregate data.

Submit Eight Data Files

EPIC

D1: Premium and Life Years

- Issuer or TPA Name
- Issuer or TPA EIN
- State
- Market Segment
- The average number of members throughout the year
- Earned premium (fully-insured)
- Premium equivalents (self-funded)
- ASO and TPA fees paid
- Stop loss premium paid
- Average monthly employee premium
- Average monthly employer premium

Narrative Response

A narrative response is required. Refer to the instructions for details on the content and manner of the narrative response. The narrative response may be submitted as a word document or pdf.

Content

- Employer size (self-funded plans)
- Net payments from federal or state reinsurance or cost-sharing reduction programs
- Drugs missing from the CMS crosswalk
- Medical benefit drugs
- Prescription benefit drugs
- Allocation method for prescription drug rebates
- Impact of prescription drug rebates

Confirm Submission

EPIC

- Currently CMS does not have a notification system to alert an employer when a report has been submitted on their behalf
- Employers should track when reporting entities submitted data files and what files were submitted

Common Questions & Scenarios

Will my fully insured carrier submit this on my behalf?

- Fully insured carriers should handle this reporting for their clients
- Obtain confirmation in writing that the fully insured carrier will report on the client's behalf
  - Written confirmation will transfer liability for the submission to the carrier

Will self-funded employers need to file any information themselves?

- TPAs and PBMs will likely submit data files D2-D8 and the corresponding plan and narrative files
- It's possible that the vendors will not submit the D1 file and its corresponding plan and narrative files

Will this requirement be delayed?

- There are no indications that the Departments will delay the reporting requirement

What is the penalty for non-compliance?

- It is likely that an IRS daily penalty of $100 per violation per day could be imposed for non-compliance

Common Questions & Scenarios

EPIC

What happens if the carrier doesn't have all the information necessary to complete the requirement?

- For **2020 and 2021 reference years only** there is no enforcement for the data reporting requirement surrounding premium contributions
  - If a reporting entity does not have this information they can report without it
  - Plans must provide this information starting with reference year 2022 reporting due June 1, 2023

How do I know how different TPAs and PBMs are handling this new requirement?

- TPA and PBM involvement varies
- EPIC is collecting information from vendors on how they are handling the requirements

Common Questions & Scenarios

EPIC

Multiple vendors reporting for the same employer

- It is likely that plans will have more than one vendor contributing to their report
    - Some coordination will be required
- Reporting entities should coordinate so they do not provide duplicate information
- CMS encourages TPAs/PBMs to work together to create one data file
    - CMS confirmed that multiple data files from different vendors may be submitted for the same employer without being aggregated together
- Example: If reporting entities cannot work together to submit one data file CMS will accept submissions of D3 – D8 from two different PBMs covering the same portion of the reference year for the same plan.
- Reporting entities may only view the information they have submitted
- We expect additional guidance on this issue in the coming weeks

Common Questions & Scenarios

EPIC

Changing vendors midyear

- Plans that switch vendors (such as changing a TPA or PBM) during the reference year have two reporting options:
  - The previous vendor reports the data from earlier in the year and the new vendor reports the data from later in the year; or
  - The previous vendor provides the data to the new vendor and the new vendor reports the entire year of data
- Practically speaking vendors may not want to provide their data to a new vendor
- Vendors will likely require an NDA before releasing data to a client

Fully Insured Plans Next Steps

EPIC

- Fully insured employers should obtain confirmation in writing that the carriers will take full responsibility for reporting
  - EPIC is reaching out to carriers, TPAs, and PBMS to determine their level of involvement
- For 2020 and 2021 reference years only there is no enforcement for data on premium contributions that fully insured carriers are not able to obtain
- Confirm that data was submitted in advance of the deadline

Self-Funded Plans – Next Steps

EPIC

- Self-funded employer considerations:
  - What data the TPA/PBM will provide
  - What data the TPA/PBM will submit
  - Whether a previous vendor will submit on a client's behalf
  - Whether a previous vendor requires an NDA before releasing data
- Clients may be responsible for submitting the P2 and D1 files themselves
- Determine if vendors will require any additional fees for submission
- Confirm that the data was submitted in advance of the deadline

NOTE: Most level funded plans are **self-funded**, reach out to carriers/TPAs of level funded plans to determine the level of assistance the vendors will be providing

EPIC is reviewing TPA/PBM involvement and determining the best way we can support our clients.

3

Questions?