TRUMP ADMINISTRATION PROPOSES NEW TRANSPARENCY REGULATIONS

Editor's Note: This topic will be addressed in more detail during SIIA's upcoming Healthcare Price Transparency Forum, scheduled for February 25-26 in Jacksonville, FL. Event details can be accessed at www.siia.org.

Written By Chris Condeluci, Esq.

A Quick Refresher on the TiC Regulations

Way back in October 2020, the first Trump Administration finalized regulations – known as the "Transparency in Coverage" or "TiC" regulations – requiring self-insured plans and insurance carriers to publicly disclose through three distinct Machine-Readable Files ("MRFs"):

- In-network negotiated ("INN") rates for covered medical items and services (known as the "INN Rate File").
- Out-of-network ("OON") allowed amounts the plan or carrier paid to out-of-network providers (known as the "OON Allowed Amounts File").
- INN rates and the historical "net price" for covered prescription drugs (known as the "Prescription Drug File").

These final regulations also require carriers and self-insured plans to provide participants with cost-sharing liability information for medical items and services covered under the plan or policy through an electronic, online tool that can be accessed directly by participants at any given time during the year.

PROBLEMS WITH THE PUBLIC DISCLOSURE OF PRICING INFORMATION

Over the course of the past four years in which the TiC regulations have been effective, self-insured plan sponsors and their service providers have discovered that these MRFs (in particular, the INN Rate File and the OON Allowed Amounts File) are way too large, which has made it extremely difficult for plan sponsors and their service providers to download, analyze, and evaluate the publicly disclosed pricing information. In addition, sponsors and service providers have found that the pricing data input into the MRFs is often incorrect, inaccurate, and duplicative, which has made it almost impossible to develop an accurate picture of the pricing information and provider patterns in a particular geographic region.

Another significant issue is the lack of compliance with the TiC regulatory requirements, which many believe is the root cause of (1) the large-scale size of the INN Rate and OON Allowed Amounts Files and (2) the disclosure of incorrect, inaccurate, and duplicative pricing data. Many industry stakeholders actually believe this non-compliance is purposeful (especially in the case of insurance carriers that "rent" their provider networks to self-insured plans) and is intended to continue to shroud the full disclosure of pricing information for medical items and services and prescription drugs.

SOUNDING THE ALARM

Over the past four years, self-insured plan sponsors and their service providers have been sounding the alarm about all of the problems noted above, and we have encouraged the Federal Departments to issue new regulations that would improve and strengthen the existing TiC regulations.

ASK, AND YOU SHALL RECEIVE...WELL SORT OF

The Federal Departments listened, and just a few days before the recent Christmas Holiday (on December 19th), they finally issued proposed regulations that are intended to address the problems noted above.

Much to our chagrin, however, these proposed regulations do not include any new enforcement provisions, such as requiring the CEO or authorized representative of an insurance carrier to "attest" to the accuracy of the pricing data included in the carrier's INN Rate and OON Allowed Amounts Files or increasing penalties for non-compliance, which is something we were expecting. These proposed regulations also do not include specific provisions implementing the Prescription Drug File, which is something we were hoping to see.

SOME OF THE MOST HELPFUL ASPECTS OF THESE PROPOSED REGULATIONS

These proposed TiC regulations are technical and dense at times, so I don't want to get into the weeds of each and every proposed change to the existing TiC regulations. However, I did want to take a moment to describe what I believe to be the most helpful aspects of these proposed regulations:

FOUR NEW FILES TO HELP PLAN SPONSORS BETTER UNDERSTAND THE PRICING DATA

Over the course of the past four years, the Federal Departments have come to realize that additional information relating to the publicly disclosed pricing data is necessary to promote a fuller understanding of pricing dynamics. In response, the Departments are now proposing to require insurance carriers and self-insured plans to develop and post four new Files to provide what the Departments are calling "additional context" to the INN Rate File. These new – and separate and distinct – Files include a:

- Change Log File
- Utilization File
- Taxonomy File
- Text File

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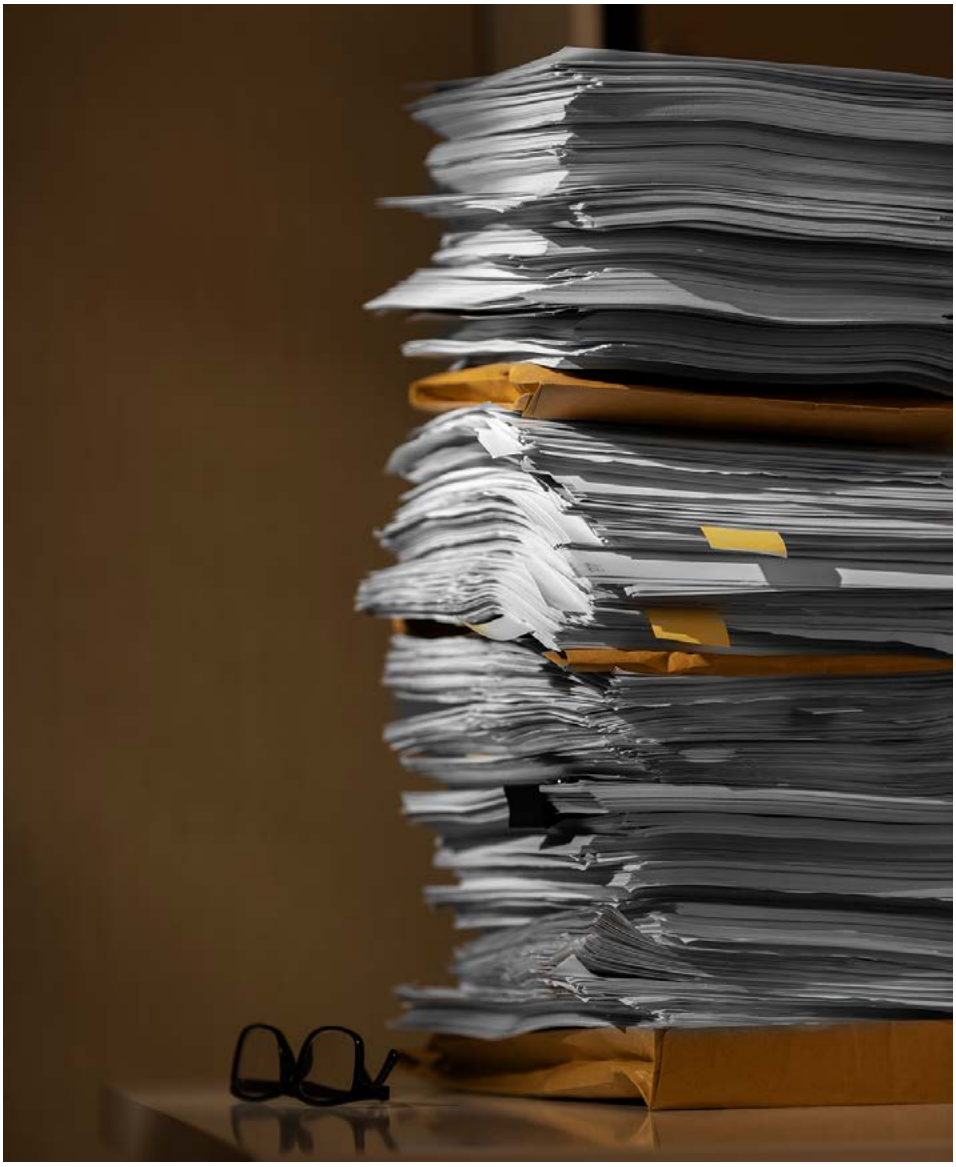
CHANGE LOG FILE

This Change Log File must be prepared for each INN Rate File, and each respective Change Log File must identify any changes made to the pricing information in the corresponding INN Rate File since the immediately preceding publication of that INN Rate File.

The Change Log File must take the form of an MRF, and the Change Log File for a particular INN Rate File must be updated and posted quarterly, whether or not there are changes to the corresponding INN Rate File since that INN Rate File was last posted.

The purpose of this new Change Log File is to help patients, researchers, plan sponsors, and policymakers identify changes to the pricing information in the INN Rate File from one reporting period to the next. This will effectively eliminate the need to crosswalk old INN Rate Files with new INN Rate Files to figure out what pricing data may have changed.



UTILIZATION FILE

Self-insured plans and insurance carriers must also develop a Utilization File which would document all items and services covered under the plans or policies represented in the INN Rate File for which a claim has been submitted and reimbursed.

The Utilization File would also include each INN provider – identified by the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code – who was reimbursed for a claim for each covered item or service included in the INN Rate File.

The Utilization File must also take the form of an MRF, and this Utilization File must be updated and posted annually.

The Federal Departments explained that the purpose of this Utilization File is to reveal which providers are actively serving participants and delivering covered items and services within a self-insured plan's or insurance carrier's network. If a provider appears in a plan's or carrier's INN Rate File but does not appear in the plan's or carrier's Utilization File, then patients, researchers, plan sponsors, and policymakers may reasonably conclude that that provider, despite having a negotiated rate, has had no recent interactions with that plan's or carrier's participants. The Departments also explained that extending this type of analysis to all providers for a plan or carrier's network

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TAXONOMY FILE

The proposed regulations would require insurance carriers and self-insured plans to make available a Taxonomy File that includes the plan's or carrier's internal provider taxonomy, which maps items and services (represented by a billing code) to provider specialties (represented by specialty code as established by the National Uniform Claim Committee ("NUCC")) to determine if the plan or carrier should deny reimbursement for an item or service because it was not furnished by a provider in an appropriate specialty.

The Taxonomy File must take the form of an MRF, and the Taxonomy File must be updated and posted quarterly. If there are no changes to the taxonomy that affect the information required to be included in the Taxonomy File in a subsequent quarter, the Taxonomy File would not be required to be updated for that quarter.

The Departments explained that this Taxonomy File would provide transparency into how plans and carriers determine whether to exclude certain provider-rate combinations from an INN Rate File, which will be helpful in eliminating "ghost rates" (discussed more fully below). Requiring the Taxonomy File would also offer plan sponsors and researchers potentially valuable insights into the degree of standardization in mapping used by plans and carriers, and how this varies across different market types. And most importantly, the Taxonomy File would offer new information to potentially guide future rate negotiations between plans, carriers and providers, particularly concerning the scope of reimbursable services by provider type to include in contract discussions.

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TEXT FILE

The website of an insurance carrier, a self-insured plan, or a service provider on behalf of a self-insured plan must prominently display a Text File that includes a web link to the internet website that hosts the INN Rate File and the OON Allowed Amount File.

The Text File must also include point-of-contact information, including an up-to-date name, title, and email address for an individual who works for the carrier, plan, or service provider who can address questions and issues related to these MRFs. Note, the point-of-contact information must also be prominently displayed on the same website that hosts the INN Rate File and the OON Allowed Amount File.

The Text File must take the form of an MRF, and the Text File must be updated not later than 7 calendar days following a change in the point-of-contact information or the URL links.

The purpose of prominently displaying a web link to the website that hosts these MRFs is to make it easier for patients, researchers, plan sponsors, and policymakers to locate the pricing information. The purpose of the point-of-contact information is to allow patients, researchers, plan sponsors, and policymakers to contact an actual representative of the carrier, plan, or service provider who can help in verifying the contents of the INN Rate File and/or OON Allowed Amount File and respond to requests for assistance related to accessing and utilizing these MRFs.

PROPOSED CHANGES TO THE INN RATE FILE

Organizing INN Rate Files by Provider Network

Insurance carriers and self-insured plans often use the same medical provider network for participants covered under multiple policies and health plans offered by these carriers and plan sponsors. The proposed regulations would require carriers and plans to prepare one File for this particular provider network that may then be used by all of these different self-insured health plans and insurance policies, instead of preparing multiple Files for each and every plan and policy.

The Departments explained that where multiple plans share the same negotiated rates under an umbrella provider network, organizing INN Rate Files by provider network would decrease the size of the Files while also maintaining data integrity. The Departments further noted that this would also reduce the total number of INN Rate Files because there are far more available plans and policies than there are distinct, separately managed provider networks.

Reporting By Product Type

The Departments also propose to require plans and carriers to report the product type (e.g., Health Maintenance Organization ("HMO") or Preferred Provider Organization ("PPO")) associated with the coverage option for which data is being reported in the INN Rate File.

The Departments explained that product types dictate the fundamental relationship between the payer and the provider regarding patient access and volume, which are key leverage points in contract negotiations over rates. For example, in instances where HMOs may have narrow networks, providers contracting with such HMOs are likely to see increased patient volume, which may encourage such providers to contract at a lower rate with the HMO than they might with a PPO that is less likely to result in higher patient volume.

Product types also dictate the fundamental relationship between payer and patient, with differences, for example, related to patient choice, cost-sharing responsibilities, and accessibility.

In addition, INN rates for particular covered items and services differ based on product type, so requiring plans and carriers to include the product type for each coverage option in the INN Rate File would reflect these differences.

Enrollment Totals

The proposed regulations would require each INN Rate File to include current numerical enrollment totals, as of the date the File is posted, for each coverage option offered by a plan or carrier that uses the File's provider network. Such numerical enrollment totals must include the number of participants (including all dependents) in the coverage option offered by a plan or carrier.

Eliminating "Ghost Rates"

One reason the INN Rate Files are so large is due to the inclusion of providers associated with INN rates for items or services they are not likely to furnish (e.g., rates for podiatrists to perform heart surgery).

The proposed regulations would effectively eliminate the public disclosure of these rates (often referred to as "ghost rates," which are medical prices that are listed for items and services that participants never utilize, and medical providers never furnish, making the pricing data misleading).

Here, plans and carriers would be required to exclude from each INN Rate File (1) the provider and (2) this provider's INN rate (i.e., the provider-rate combination) for an item or service if that plan or carrier determines that it is unlikely that such provider would be reimbursed for the item or service based on the scope of the provider's license or area of specialty. To make such a determination, the plan or carrier must use its internal provider taxonomy that is typically used during the claims adjudication process. The proposed Taxonomy File (discussed above) is intended to assist in making determinations to exclude "ghost rates" from the INN Rate Files.

Special Rule for Self-Insured Plans for INN Rate Files

Self-insured plans may allow their service provider to make available a single INN Rate File for each provider network used by more than one self-insured plan. In other words, the INN Rate File may be made available at the "service provider-level" for each provider network used by the self-insured plan, and the INN Rate File could include such information for more than one self-insured plan with which the service provider administers. In cases where the service provider is an insurance carrier that "rents" the carrier's provider network to the self-insured plan, the INN Rate File shall also include INN rates from the carrier's policies that use the same provider network as the self-insured plans.

The goal of this proposal is to reduce the size of INN Rate Files, as well as the number of INN Rate Files. And, to accomplish this goal, it makes sense to allow a self-insured plan to allow its service provider to include plans and coverage offered in different health insurance markets in the same INN Rate File to the extent the self-insured plans and fully-insured plans use the same provider network.

PROPOSED CHANGES TO THE OON ALLOWED AMOUNT FILE

The Federal Departments have emphasized that the transparency of OON payment data is vital for plan sponsors, researchers, and policymakers to analyze healthcare spending, benchmark costs, and inform future policy decisions. The Departments believe that OON pricing data offers insight into actual healthcare expenditures, including a window into the price of an item or service in the context of an arms-length transaction between a provider and a plan or carrier who have not negotiated the rate, and where there is therefore no discount associated with the advantage to a provider of being "in network."

To this end – and to also address the problem that not enough OON payment data is being publicly disclosed in the OON Allowed Amount Files – the Departments would:

- Require more disclosures of OON payments by lowering the number of claims that must be incurred before the public disclosure requirement is triggered – from 20 claims to 11 claims; and
- Increase (1) the period for reporting OON payment data from 90 days to 6 months and (2) the lookback period for purposes of reporting the OON payment data from 180 days to 9 months.

The Departments would also require insurance carriers and self-insured plans to list out in one File all of the payments for OON services in each health insurance market that are above the newly proposed 11-claim disclosure threshold.

And, similar to the proposed changes to the INN Rate File (discussed above), the Departments would require carriers and plans to report the product type (e.g., HMO or PPO) for the coverage option for which payment data is being reported in the OON Allowed Amount File.

Lowering Claims Threshold Triggering Public Disclosure

In an effort to protect the privacy of health information (and to protect participants from identification based on information disclosed in the OON Allowed Amount File), the original TiC regulations did not require a self-insured plan or insurance carrier to disclose OON payment data in relation to a provider for a medical item or service if less than 20 different claims are filed by that particular provider for the particular medical item or service.

As stated, the proposed regulations would lower the threshold for including claims in the ONN Allowed Amount File from 20 to 11 different claims per item or service in a particular health insurance market.

The Departments also clarify that this 11-claims threshold pertains to the number of claims for a particular item or service, not the number of claims for a particular item or service from a particular provider.

Increasing the Reporting and Lookback Periods

The Departments propose to increase the reporting period from the current 90 days to 6 months and also propose to increase the lookback period from the current 180 days to 9 months. In other words, plans

and carriers would be required to include in their OON Allowed Amount Files allowed amounts and billed charges with respect to covered items or services furnished by OON providers during a 6-month time period that begins 9 months prior to the publication date of the OON Allowed Amount File. In this case, if the OON Allowed Amount File was published on June 30, 2027, the File must include data for the 6-month period beginning on October 1, 2026.

Aggregating OON Data by Health Insurance Market

Self-insured plans and insurance carriers must also report ONN payments and billed charges at the "health insurance market-level," rather than the "plan or policy-level."

For example, if an insurance carrier offers four individual market plans, six small group market plans, and eight large group market plans, this carrier would be required to make available three separate OON Allowed Amount Files:

- One File that aggregates the OON allowed amounts across the carrier's 4 individual market plans;
- One File that aggregates the OON allowed amounts across its six small group market plans; and
- One File that aggregates the OON allowed amounts across its eight large group market plans.

For self-insured plans, the Departments would allow a service provider that administers self-insured plans for multiple plan sponsors to aggregate ALL of the self-insured plans that this service provider administers together, and then aggregate ALL of the OON allowed amounts for ALL of these self-insured plans, and then input ALL of these OON allowed amounts on a single OON Allowed Amount File that each of the service provider's self-insured plan sponsor clients can post.

This would mean that a self-insured plan may permit its service provider to include its required OON payments and billed charges information in a single OON Allowed Amount File, along with OON payments and billed charges information from multiple other self-insured plans with which the service provider administers. In cases where the service provider is also an insurance carrier, the OON allowed amount and billed charges information from the carrier's fully insured plans must not be included.

Reporting By Product Type

As stated, carriers and plans would be required to report in the OON Allowed Amount File the product type to which the OON payment data is associated.

In the Department's opinion, adding a product type to the OON Allowed Amount Files would allow patients, researchers, and plan sponsors to compare how historical provider reimbursements differ based on product type, which would enable more accurate and actionable comparisons so they can understand true market pricing for specific product types.

THE FIDUCIARY ANGLE

Self-insured health plan sponsors are considered fiduciaries under the Employee Retirement Income Security Act ("ERISA"). As an ERISA fiduciary, these plan sponsors must, among other things:

- Make prudent decisions.
- Act in the best interests of plan participants.
- Keep health plan costs low.
- Monitor plan service providers.

If a plan sponsor does not have access to complete and accurate pricing data for the medical items or services and prescription drugs covered under the plan, the plan sponsor:

- CANNOT act prudently and re-negotiate with the plan's existing owner of the provider network or discontinue the plan's relationship with this service provider.
- CANNOT act in the best interests of participants because the sponsor cannot consider contracting with an owner of the provider network that is charging lower prices for covered benefits.
- CANNOT keep health plan costs low because the sponsor cannot compare the medical and prescription drug prices paid by the plan with the prices negotiated by a different owner of a provider network that the sponsor may consider contracting with.
- CANNOT monitor plan service providers to make sure their existing owner of the provider network is negotiating the most reasonable rates for covered medical items and services, and prescription drugs.

The bottom line is that a plan sponsor NEEDS access to complete and accurate pricing data to satisfy their ERISA fiduciary duties, and without such access, plan sponsors are exposed to fiduciary liability.

Having said all of that, here are some things that the proposed changes to the INN Rate File would help plan sponsors – as ERISA fiduciaries – do:

- By organizing the INN Rate File by provider network, this should make it easier for plan sponsors to analyze the INN rates of different provider networks to make informed decisions about which plans to offer their employees, potentially favoring provider networks with more competitive pricing, in addition to opening the door for plan sponsors to bring healthcare purchasing decisions in-house through direct contracting with provider groups.

- Similarly, by organizing INN rate information by provider network, this should help service providers advise plan sponsor-clients on provider network selection and cost management strategies.

- When it comes to enrollment totals in the INN Rate File, this should allow plan sponsors to weigh different plan and coverage options to understand their relative influence on the overall landscape of healthcare pricing. This should, in turn, enable plan sponsors to develop analytical models that prioritize INN rates for particular items and services based on the number of individuals covered by the corresponding plan or coverage, thereby focusing analysis on prices with the broadest impact on the insured population.

With respect to the proposed changes to the OON Allowed Amount File, here are some things that plan sponsors – as ERISA fiduciaries – can do:

- With OON allowed amounts tied to product type, plan sponsors may better understand the actual tradeoffs in plan design – not just premiums and network access – but also how much the plan will pay when employees go OON.
- Also, with the inclusion of data on product type, plan sponsors could use historical allowed amounts segmented by product type to evaluate the level of financial protection offered for OON services. For example, a plan sponsor offering a PPO plan could benchmark their OON costs specifically against other PPO plans in the market, rather than a generalized average that includes potentially lower-cost HMOs, and they could use this information to make future plan coverage determinations.
- Plan sponsors can also use this data to benchmark costs, refine benefit designs, and negotiate more effectively with providers and owners of the provider network.

WHAT'S NEXT?

Public comments on these proposed TiC regulations are due February 23rd. It will likely take the Federal Departments six months or more (1) to review the comments and then (2) to finalize the proposed changes, so don't expect final regulations until at least the 3rd Quarter of 2026, at the earliest.

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Note, some of these proposed changes may themselves change when the regulations are ultimately finalized based on stakeholder feedback. In many cases, however, there are not a lot of substantive changes made to what the Departments actually propose. But stay tuned.

Also, stay tuned for additional guidance and regulations from the Federal Departments on price transparency. We are anxiously awaiting a Transparency 3.0 exercise, within which we will hopefully see guidance or regulations increasing enforcement for non-compliance with the TiC requirements. We are also hopeful that we will see a separate and distinct regulation implementing the Prescription Drug File. Guidance on the Prescription Drug File is long overdue. ■

Chris Condeluci serves as SIIA's Legal and Policy Advisor. He can be reached at ccondeluci@siia.org.