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New Federal Transparency Requirements Impacting Health Providers and Plans

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As promised, this is a follow-up to our first blog post on the new federal transparency requirements. In our prior post, we summarized the Hospital Price Transparency rule which went into effect on January 1, 2021, and here we discuss the transparency rules contained in the Consolidated Appropriations Act, 2021 (the "Act"), which apply to both health plans and health care providers.

Beginning January 1, 2022, the Act requires providers (individual practitioners and facilities) to send the health plan a "good faith estimated amount" of scheduled services, including any expected ancillary services and the expected billing and diagnostic codes for all items and services to be provided. This notice then triggers the health plan's obligation to send enrollees an "Advanced Explanations of Benefits" ("AEOB") prior to scheduled care (or upon patient request). If the patient is uninsured, the provider must send the notice directly to the patient.

The health plan must provide the AEOB by mail or electronically (based on patient preference) either within three business days of receiving a request or a notice that a service has been scheduled if the service is scheduled at least 10 business days later, or within one business day of receiving the notice if the service is scheduled within 10 business days of receipt.

The AEOB provided by the health plan to the enrollee must contain:

1. The network status of the provider. If the provider is in-network, the health plan will need to include the contracted rate for the item or service, based on the billing and diagnostic codes sent by the provider. If the provider is out-of-network, the health plan must include a description of how the patient can obtain information on in-network providers delivering that item or service.
2. The "good faith estimate" of expected charges, including likely billing and diagnostic codes sent by the provider.

3. A “good faith estimate” of the plan’s payment responsibility.
4. A “good faith estimate” of the patient’s expected cost-sharing amount.
5. A “good faith estimate” of the amount the patient has incurred toward meeting their financial responsibility limits, such as their deductible and out-of-pocket maximums.
6. If applicable, a disclaimer that coverage for the item or service is subject to a certain medical management technique (*g.,* prior authorization).
7. A disclaimer that all information included in the notice is an estimate based on the information known at the time of scheduling (or requesting) and is subject to change.
8. Any other information or disclaimers the health plans determine is appropriate for this notice.

In addition to the AOEB requirement, the Act also imposes additional transparency requirements on plans and providers:

- **Online Directory**: Health plans must establish and maintain an online directory listing the names of contracted providers, addresses, specialties, telephone numbers, and digital contact information. The information must be verified and updated at least every 90 days, but must be updated within two business days of receiving new information from a provider. If the health plan is unable to verify the accuracy of a provider’s information, the health plan must have procedures for removing these providers. In order to do this, providers must have a practice in place to ensure timely provision of directory information to a plan. At a minimum, the provider must submit notice to the plan each time the provider (a) begins a network agreement with a plan with respect to certain coverage; (b) terminates an agreement; or (c) makes any material changes to the content of the provider directory information.
- **Price Comparison Tools**: Health plans must also maintain online price comparison tools that will allow patients to compare expected out-of-pocket costs for items and services across multiple providers. Health plans also will need to provide price comparisons over the phone.

Regulations have not yet been issued, and will be controlled by the Biden administration, which will have substantial discretion in the implementation of that Act.

In sum, the requirements of the Act, assuming they are implemented by the new administration, will enhance transparency and the patient experience, but at substantial cost. This process change for health insurance claims will likely be extremely expensive and disruptive, and payers and providers may find themselves faced with price expectations tied to the AEOB even when facts change and there is a disclaimer that notes the inherent limitation and uncertainty of the AEOB.

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