Advance Access to Prices for Health Services Coming in 2022

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CLIENT ALERT | 1.26.2021

The Consolidated Appropriations Act (CAA), signed December 27, 2020, will bring significant changes to group health plans in 2022. This alert addresses how the CAA will require group health plans to provide advance access to the prices for health care services starting in 2022.

Why prices matter to participants

What a participant has to pay for a health care service depends on both group health plan design and the charge for a health care service.

A group health plan must cover preventive services without participant cost sharing and may cover some services (e.g., a primary care provider office visit) subject to a fixed dollar copay. Typically, other services (and in the case of an HSA-compatible high deductible health plan, all services other than preventive care) are subject to participant cost sharing in the form of a deductible and coinsurance.

A deductible is the dollar amount of provider charges that a participant must pay each year before the group health plan starts to share the cost of health care services. Coinsurance is the percentage of provider charges that a participant must pay after meeting the deductible.

Even if a participant knows his or her group health plan's deductible and coinsurance, he or she cannot calculate his or her share of the cost without also knowing a provider's charge for a service. For example, if a participant is enrolled in a group health plan with a deductible of $1,500 and coinsurance of 20%, the participant could not calculate his or her share of the cost for a scheduled service without also knowing whether the provider's charge for a service would be, e.g., $300 or $3,000. In addition, if the provider is a nonparticipating provider, the participant may also be responsible for a balance bill. (See Surprise Medical Billing Protections Coming in 2022 for an explanation of balance billing.)

To date (and with the exception of retail healthcare clinics which often post set prices for services), it has been difficult to get upfront estimates of charges for health care services. That is supposed to change in 2022.

Access to prices with an advance EOB

Starting in 2022, the CAA requires that a participant get an advance explanation of benefits (EOB) whenever he or she schedules a health care service at least three business days in advance. In addition, a participant will be able to request an advance EOB for a service regardless of whether the service has been scheduled. Here is how the advance EOB process is supposed to happen:

Step 1: The provider gives the group health plan an estimate of charges for scheduled services

When a participant schedules a service at least three business days in advance, the provider is supposed to give the participant's group health plan a good faith estimate of expected charges.

The provider needs to act quickly: If the participant schedules at least 10 business days in advance (or requests an advance EOB for a service that has not been scheduled), the provider is supposed to provide the estimate to the group health plan within three business days of scheduling. If the participant schedules at least three (but less than 10) business days in advance, the provider is supposed to provide the estimate to the group health plan within one business day of scheduling.

Step 2: The group health plan gives the participant an advance EOB

When the group health plan receives the estimate from the provider, the group health plan is supposed to give the participant an advance EOB that includes:

- Whether the provider in question is a participating provider.
  - If yes, the contracted rate for the scheduled item or service.
  - If no, a description of how the participant may obtain information on participating providers.
- The good faith estimate of charges (received from the provider in step 1).
- A good faith estimate of the amount that the group health plan will pay, the participant's cost sharing, and the year-to-date accumulation toward the participant's deductible and out-of-pocket maximum.
- A disclaimer on medical management (if applicable).

The group health plan also has a tight timeframe: If the participant schedules at least 10 business days in advance (or requests an advance EOB for a service that has not been scheduled), the group health plan is supposed to provide the notice to the participant within three business days of receiving the provider's estimate. If the participant schedules at least three (but less than 10) business days in advance, the group health plan is supposed to provide the notice to the participant within one business day of receiving the provider's estimate.

Access to prices with an internet-based self-service tool

Starting with the 2022 plan year, the CAA directs group health plans to offer "price comparison guidance" over the phone and over the internet "to the extent practicable." That doesn't sound onerous. But, wait, there is more...

Starting with the 2023 plan year, tri-agency (IRS, DOL and HHS) price transparency regulations published November 12, 2020 will require a group health plan to have an internet-based self-service tool that participants can use to check prices. The price transparency regulations were issued under the Affordable Care Act (ACA) and so are independent of the CAA. However, we expect that the tri-agencies will try to construe the CAA requirements consistently with the price transparency regulations. Note that the Biden Administration has the opportunity to suspend the price transparency regulations but is not currently expected to do so.

The price transparency regulations will require a group health plan to make available an internet-based self-service tool that can display:

1. a participant's estimated cost-sharing liability;
2. the year-to-date accumulation toward the participant's deductible and out-of-pocket maximum;
3. the negotiated rate for an item or service from a participating provider;
4. the allowed amount for an item or service from a nonparticipating provider;
5. a list of items and services subject to a bundled payment arrangement, if applicable;
6. prerequisites such as prior authorization and step therapy, if applicable; and
7. a notice including (a) an explanation of balance billing, (b) a caution that amounts shown are only estimates and that actual charges and cost sharing may be different, and (c) information as to whether copay assistance counts toward a participant's deductible and out-of-pocket maximum.

In 2023, the tool is supposed to be able to provide this information for 500 shoppable items and services (including prescription drugs) identified by the tri-agencies. Starting in 2024, the tool is supposed to be able to provide this information for all covered items and services.

Now what?

Group health plans and providers are faced with the daunting task of collecting data from multiple sources and organizing that data in new ways to provide the required price transparency. You may want to start conversations with your group health plan's claims administrator as to its preparations. In addition, many vendor contracts will need to be amended to reflect the need to perform new tasks. An employer retains legal responsibility for a self-insured group health plan's compliance but, for something like this, the employer is going to have to rely on its claims administrator to put in place legally compliant processes.

Expect more detail and direction when the tri-agencies publish regulations.