Request for information to use in implementation of machine-readable files under House Bill 2090, and stakeholder notice

Stakeholder meeting date: October 27, 2021

Time: 9 a.m.–10:30 a.m.

Location: Register on Zoom. After you register, you will get an email with instructions for joining the meeting and an option to add the meeting to your calendar.

Details:

The Texas Department of Insurance (TDI) is developing a rule required under Insurance Code Section 1662.107, as added by Section 3 of House Bill 2090 from the 2021 regular legislative session.

Subchapter C of Insurance Code Chapter 1662 requires health benefit plans that are not subject to the federal "Transparency in Coverage" rule to publish three machine-readable files containing price transparency information online in "a form and manner prescribed by department rule."

To provide input:

Please provide your comments to LHLcomments@tdi.texas.gov by 5 p.m., Central time, October 27, 2021. TDI will host an online public stakeholder meeting to discuss the comments on October 27 at 9 a.m., Central time. TDI will publish the comments submitted on the TDI website. Please note that this request for information pertains only to the implementation of Section 3 of HB 2090.

Applicability

1. Insurance Code Chapter 1662, Subchapter C, applies to health benefit plans defined in Insurance Code Section 1662.003 that are not subject to the federal "Transparency in Coverage" rules under 26 CFR Part 54, 29 CFR Part 2590, and 45 CFR Parts 147 and 158.

   Please provide input on TDI's consideration of a rule that would clarify that applicable plans include grandfathered health plans, short-term limited duration insurance, and health care programs operated under Health and Safety Code Section 75.104.

Small Issuer Exemption

2. TDI recognizes that the complexity associated with publishing machine-readable files may be challenging for smaller issuers and those who are not subject to the federal requirements to publish these files. Please provide input on TDI's authority to adopt a rule that would provide an exemption for issuers that have fewer than 1,000 enrollees in applicable health benefit plans, as of December 31 in the previous year.

Initial Data Publication Date

3. TDI recognizes that issuers will need sufficient time to implement the new requirements, following publication of the rule. Please provide input on TDI's consideration of a rule that would require publication of machine-readable files 180 days after the date the rules are adopted.

Form and Manner of Publication

4. For issuers that are subject to this rule and affiliated with entities that are subject to the federal rules, any divergence from the federal guidance may create administrative challenges. Please provide input on TDI's consideration of a rule that would align with the federal guidance that has been published so far and provide a safe harbor for any entity that is in compliance with the federal requirements.

Additional Comments

5. Please provide any additional comments or points of clarification that the rule should address.

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

October 22, 2021

Attention: LHLcomments@tdi.texas.gov
Cassie Brown, Commissioner of Insurance
Texas Department of Insurance

RE: AHIP Comments on HB 2090 (Section 3) Request for Information

Dear Commissioner Brown,

On behalf of AHIP[1], I write today in response to the Texas Department of Insurance's (TDI) Request for Information on the implementation of HB 2090, legislation that requires certain health plans to publish machine-readable files (MRFs) containing information on payment rates for in-network and out-of-network (OON) services and prescription drugs. The new law applies to health plans that are not subject to the federal Transparency in Coverage (TiC) rule (i.e., 26 C.F.R. Part 54, 29 C.F.R. Part 2590, and 45 C.F.R. Parts 147 and 158) and directs TDI to develop rules regarding the form and manner of the MRFs containing the price transparency information.

AHIP believes all Americans should have access to meaningful, personalized, accurate information on health care costs and quality so they can make informed decisions about their health care when researching health care providers and prescription drug costs and when scheduling health care services. This information should empower patients and consumers to seek and receive care from health providers based on accurate, personally-relevant information about cost and quality. When implemented appropriately, price and quality transparency should simultaneously enhance consumers' health care experience and, on average, push prices and costs down—not up—for consumers (and payers like employers). AHIP and our member health insurance providers know that consumer-focused transparency strategies and tools are essential to our ability to deliver on these commitments. Over 75 percent of commercial health insurance providers already offer online cost calculator tools to their combined 120 million commercial enrollees.[2]

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

[2] AHIP Survey of member health insurance plans fielded December 5, 2019 to January 10, 2020. Additional survey results to be published on ahip.org at a later date.

AHIP has been engaged in dialogue with the U.S. Departments of Health and Human Services, Labor, and the Treasury as the Departments continue to develop guidance to implement the federal Transparency in Coverage rule. We continue to encourage the Departments to create an effective, efficient, and secure transparency framework that delivers meaningful price and cost information to consumers. Following the passage of the federal Consolidated Appropriations Act of 2021 (i.e., "No Surprises Act"), which included new transparency provisions, we have also urged the tri-agencies to create a cohesive regulatory framework without conflicting transparency requirements. Specifically, the TiC rule and section 204 of the No Surprises Act create duplicative reporting requirements for prescription drugs. In recent guidance, the Departments acknowledged this overlap and is deferring enforcement of the federal prescription drug MRF requirement until it can conduct new notice-and-comment rulemaking to consider whether the requirement is still appropriate in light of the section 204 requirement.[3] In the same FAQ, the Departments announced a delay in enforcement of the in-network and out-of-network MRFs until July 1, 2022, to provide additional time for the Departments to finalize MRF technical requirements and for health insurance providers to implement.

We appreciate this opportunity to similarly participate in TDI's stakeholder process as the Department seeks input on rulemaking related to HB 2090 and MRFs. With respect to the topics addressed in the RFI, we offer the following responses:

Small Issuer Exemption:
AHIP appreciates that TDI recognizes that the complexity associated with publishing MRFs may be challenging for smaller issuers. Issuers with smaller enrollment volumes face a disproportionate burden to undertake an IT project of this size. AHIP supports TDI's authority to adopt a rule providing an exemption for issuers that have fewer than 1,000 enrollees in applicable health plans. Further, we urge TDI to provide issuers with enrollment under 100,000 members an extended implementation timeframe. We similarly recommended to the tri-agencies that small plans with members under 100,000 have an additional three to five years to comply with transparency requirements.

Initial Data Publication Date:
AHIP agrees with TDI that issuers will need sufficient time to implement new transparency requirements following the publication of its rule. AHIP does not support TDI's consideration of a rule that would require publication of MRFs 180 days after the date the rules are adopted. Guidance for the federal transparency framework continues to evolve, and compliance is not feasible until at least one year following publication of the final implementation guidance, including all the technical specifications (e.g., MRF schema). Given the complexity of the necessary infrastructure project, the dynamic federal and state transparency requirements, and

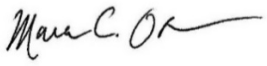
[3] FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49. August 20, 2021. v https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf

the state's responsibility for primary enforcement of the federal transparency requirements, we urge TDI to align HB 2090 implementation timelines with those for the Transparency in Coverage rule.

Form and Manner of Publication:
AHIP agrees with TDI that any divergence from the federal guidance may create administrative challenges for some issuers and could result in publication of inconsistent information. We support the Department's consideration of a rule that would align with federal guidance and provide a safe harbor for any entity that complies with the federal requirements. As noted above, the federal guidance continues to evolve, and thus ongoing synchronization with federal guidance will improve accuracy, reduce operational inefficiencies and discordant rules across markets, and increase the health care system's readiness for successful implementation of state and federal transparency requirements.

AHIP appreciates the Department's consideration of our responses to the RFI and stands ready to work with you as rulemaking moves forward. Please contact me at mosman@ahip.org or 202-578-8765 with any questions or to discuss these issues further.

Sincerely,



Mara C. Osman, J.D.
Senior Regional Director, State Affairs
America's Health Insurance Plans
mosman@ahip.org / (202) 578-8765

cc: Billy Phenix

P.O. Box 2910
Austin, Texas 78768-2910

STATE OF TEXAS
HOUSE OF REPRESENTATIVES

DUSTIN BURROWS
District 83

512-463-0542
Fax: 512-463-0671

October 22, 2021

Cassie Brown, Commissioner of Insurance
Texas Department of Insurance
333 Guadalupe Street
P.O. Box 12030
Austin, TX 78711-2030

Dear Commissioner Brown,

I am writing to you about HB 2090, which I authored and was passed during this year's regular session. I appreciate your Department seeking stakeholder feedback on this important piece of legislation. As the Department considers rule language, I ask that there be a focus on carrying out the overarching intent behind the bill while providing as much flexibility to the issuers as possible while they undergo these changes. With that in mind, I would like to provide some background on the intent behind this legislation specific to implementation of the requirements relating to machine-readable files (new ch. 1662, subch. C).

My hope was that the effective date of the subchapter on machine-readable files would align with the effective date of the federal Transparency in Coverage (TiC) rules. During the 87th Legislative Session, the TiC rules were scheduled to go into effect in January 2022, which is why Subchapter C, Chapter 1662, had the same effective date. However, the relevant federal agencies have recently announced extensions of time to comply with the new transparency federal rules, partly due to passage of the bipartisan CARES Act that also included transparency obligations; the delay until July 1st allows for better alignment between previously adopted rules and new federal laws related to transparency. I ask that the Department follow suit by confirming that the rules related to machine-readable files will not require implementation until July 2022 or on the same date that the federal rules are enforced. Aligning these dates would carry out the intent behind this legislation.

I sincerely appreciate the Department's efforts to implement HB 2090 and your careful consideration of the recommendations above. Please contact my office if you have any questions.

Sincerely,

Dustin Burrows
State Representative, Texas House District 83

EMAIL: DUSTIN.BURROWS@HOUSE.TEXAS.GOV

Texas Association of Health Plans
1001 Congress Ave., Suite 300
Austin, Texas 78701
P: 512.476.2091
www.tahp.org

October 27, 2021

Texas Department of Insurance
Via email: LHLcomments@tdi.texas.gov
Re: Request for information to use in implementation of machine-readable files under House Bill 2090

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related health care entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

We appreciate the Department's efforts to implement House Bill 2090 and provide a stakeholder meeting with an opportunity for comment. TAHP supported HB 2090 as finally negotiated, and we appreciate these steps towards more transparency for consumers. Texans should have access to meaningful information as they make decisions about their care. We believe that providing cost and quality information to the public will ultimately bring prices down for consumers and payers. However, we hope that the Department will avoid duplicative mandates and provide flexibility to issuers as they implement these new requirements.

Please see our responses to the RFI questions below.

Applicability

1. **Insurance Code Chapter 1662, Subchapter C, applies to health benefit plans defined in Insurance Code Section 1662.003 that are not subject to the federal "Transparency in Coverage" rules under 26 CFR Part 54, 29 CFR Part 2590, and 45 CFR Parts 147 and 158.**

   Please provide input on TDI's consideration of a rule that would clarify that applicable plans include grandfathered health plans, short-term limited duration insurance, and health care programs operated under Health and Safety Code Section 75.104.

   A rule on the applicability of HB 2090 would provide helpful clarity. In addition to clarifying what the law does apply to (and we do not dispute the applicability suggested

above), we also ask that TDI clarify that these requirements do not apply to Medicaid/CHIP or Medicare supplement plans. These plans are based on federal or state fee schedules with minimal to no member cost sharing. Given that the intent of the state and federal transparency rules is to lower health care costs by empowering consumers to shop and make better choices, this concept makes sense for commercial employer and individual coverage but not government programs or policies designed to work with government programs like Medicare supplement plans.

Small Issuer Exemption

2. **TDI recognizes that the complexity associated with publishing machine-readable files may be challenging for smaller issuers and those who are not subject to the federal requirements to publish these files. Please provide input on TDI's authority to adopt a rule that would provide an exemption for issuers that have fewer than 1,000 enrollees in applicable health benefit plans, as of December 31 in the previous year.**

   TDI is correct that the publication of machine-readable files would disproportionately impact small issuers. With roughly 100,000 possible codes, issuers will be required to develop teams specifically to develop these machine-readable files. Large issuers will be able to absorb the costs of these teams, albeit not easily, but small issuers will undoubtedly struggle. This could result in plans shutting down or small issuers being absorbed by larger entities, leading to less options for enrollees.

   The legislature has repeatedly shown its commitment to small businesses, and has instructed agencies to minimize adverse economic impacts: “A state agency considering adoption of a rule that would have an adverse economic effect on small businesses, micro-businesses, or rural communities shall reduce that effect.” In doing so, an agency may “exempt small businesses... from all or part of the rule.” Tex. Gov’t Code §2006.002.

   Further, in enacting a statute, “it is presumed that a just and reasonable result is intended.” Tex. Gov’t Code §311.021(3). Disproportionately burdening small businesses, and possibly leading to some Texans losing coverage, is certainly not a just and reasonable result. We ask that the Department use the discretion that the legislature has provided to exempt small benefit plans and small issuers.

Initial Data Publication Date

3. **TDI recognizes that issuers will need sufficient time to implement the new requirements, following publication of the rule. Please provide input on TDI's consideration of a rule that would require publication of machine-readable files 180 days after the date the rules are adopted.**

   TAHP agrees strongly that plans subject to HB 2090 should be given sufficient time to implement the new requirements. However, rather than selecting an arbitrary number of days after rule adoption, we recommend that TDI align the effective date of the

transparency rules with the new effective date of the federal transparency rules, including any subsequent guidance or updates.

After the federal Transparency in Coverage (TiC) Final Rules were finalized, Congress enacted the Consolidated Appropriations Act (CAA), which imposes important new transparency requirements on plans and issuers. These requirements significantly changed the regulatory landscape since the TiC Final Rules were adopted. To address the later statutory enactment and stakeholder concerns, and as an exercise of enforcement discretion, the federal Departments are deferring enforcement of the requirement in the TiC Final Rules until July 1, 2022.

Requiring grandfathered plans to comply with HB 2090 prior to July 1, 2022 will cause confusion in the market place and create enormous implementation costs for health plans that must move forward sooner in Texas only for this small subset of coverage. We urge TDI to provide additional implementation time to comply with the timelines recently announced in connection with the federal transparency regulations.

Additionally, the federal drug pricing file requirements are currently deferred pending further rule making. Our understanding of the intent of HB 2090 was that TDI reporting requirements would align with the federal rules to avoid duplication of effort and costs while also making certain data could be easily integrated for use by TDI for the intended purpose of gathering a complete picture of drug pricing for Texas citizens. We respectfully request that TDI defer enforcement of any drug pricing file requirements until the final form and manner has been determined by the federal tri-agencies managing the federal reporting.

Form and Manner of Publication

4. **For issuers that are subject to this rule and affiliated with entities that are subject to the federal rules, any divergence from the federal guidance may create administrative challenges. Please provide input on TDI's consideration of a rule that would align with the federal guidance that has been published so far and provide a safe harbor for any entity that is in compliance with the federal requirements.**

   This is an excellent solution to one of the most significant concerns with this bill, which is that issuers who have both grandfathered and non-grandfathered plans will have to comply with two different regulatory frameworks at all times. While not identical, the federal transparency requirements are robust, and they align with the general intent of HB 2090. Creating a safe harbor for entities in compliance with the federal law will dramatically reduce administrative burdens, which will lead to lower premiums, while still adhering to the intent of the legislature.

TAHP and its member plans appreciate the opportunity to comment on this proposal and look forward to working with the department on implementation. Please contact me with any questions or to discuss further.

Regards,

Jamie Dudensing, RN, BSN, MPaff
CEO
Texas Association of Health Plans

Cc: Kevin Stewart
Melissa Eason
TAHP Regulatory Counsel

910 JOHN STREET · COLUMBUS, OH 43222

October 27, 2021

Attention: LHLcomments@tdi.texas.gov
Texas Department of Insurance

Re: CoverMyMeds Comments on HB 2090 Request for Information

On behalf of CoverMyMeds, I write in response to the Texas Department of Insurance's (TDI) Request for Information on the implementation of HB 2090, related to the requirement for certain health plans to publish machine-readable files containing information on payment rates for in-network and out-of-network services and prescription drugs.

About CoverMyMeds
CoverMyMeds, a part of McKesson Corporation, is a fast growing health care technology company that has a mission through innovation and collaboration, to develop solutions that help people get the medicine they need to live healthier lives by seamlessly connecting the healthcare network to improve medication access; thereby increasing speed to therapy and reducing prescription abandonment. CoverMyMeds' network includes 75 percent of electronic health record systems (EHRs), 50,000+ pharmacies, 750,000 providers and most health plans and PBMs.

Comments
We applaud TDI for making efforts to provide greater access and insight for consumers as to the cost of their medical service and prescription drug benefits. We support the effort and are in agreement with the currently outlined technical details that are required in Subchapter C, Sec. 1662.102. These required data points are relevant and should provide the needed information.

We would respectfully encourage the Department to require machine readable files to adhere to the industry accepted standards for transmission as approved by the American National Standards Institute (ANSI) accredited standards development organizations (SDO). ANSI accredited SDOs develop and approve technology standards of transmission by a collaboration of all interested stakeholders to include representation for providers, payers, patients and technology companies. The SDOs that are most applicable in the consideration of machine readable files for medical and prescription services would be Health Level 7 (HL7) and the National Council of Prescription Drug Monitoring Programs (NCPDP) respectively.

CoverMyMeds appreciates the Department's consideration of this comment and are available to work with you as rulemaking moves forward. Please contact me at trussell@covermymeds.com or 617-504-7583 with any questions or to discuss further.

Sincerely,

Tracy Russell
Sr Director of State Government Affairs
trussell@covermymeds.com
617-504-7583

Helping Consumers Identify Their Provider Networks

A Proposal for Help Consumers Learn Provider Network Participation Easily

Eric Ellsworth – Consumers' Checkbook

October 2021

CONSUMERS' CHECKBOOK

CSS Center for the Study of Services

Quick Version

- Create a standard name and code for each provider network
- Display on consumer-facing materials from plan
- Code takes consumer straight to the right provider directory for that network
- Third parties can use it to help consumers combine outside info (e.g. in-network costs, ratings, plan shopping, etc)
- Providers can use it to correctly inform consumers which insurance networks they participate in

Long Version - Contents

- Background
  - Consumer questions about providers and insurance coverage
  - Challenges navigating to online provider directories
  - Why consumers need to know their network
  - Consumers challenges in getting correct network participation info
- Proposal
  - Basic idea
  - Benefits
  - Implementation considerations
- Examples/Screenshots

Consumer Questions When Looking Up Providers

- Is my doctor (or Dr. X) covered by my insurance?
- Will I be covered if I get treatment at facility Y?
- Where is a nearby doctor who does procedure Z?
- Where is there a provider who speaks my language?
- Find a facility where my great provider can treat me?
- I've learned that Dr. A is great, which plans does s/he accept?
- If I choose health plan P, where can I go to the urgent care?
- How can I determine with confidence that Dr. Z is not covered any of the plan options I have
- How can I get up-front estimates of cost to see Dr. Q that are applicable to my specific situation?

Consumer Questions When Looking Up Providers (cont'd)

- Is my doctor (or Dr. X) covered by my insurance?
- Will I be covered if I get treatment at facility Y?

⇐ Existing provider directories do OK at answering these (subject to accuracy issues, navigation challenges for non-members)

- Where is a nearby doctor who does procedure Z?
- Where is there a provider who speaks my language?
- Find a facility where my great provider can treat me

⇐ Third party sites for researching/choosing providers and plans can answer these questions well

- I've learned that Dr. A is great, which plans does s/he accept?
- If I choose health plan P, where can I go to the urgent care?

⇐ Challenging for third party sites to get good data to link their data on providers with the networks and plans they are in

- How can I determine with confidence that Dr. Z is <u>not covered</u> any of the plan options I have

Very hard to be certain that a doctor is not in-network, especially across many plans) -- Especially relevant for behavioral health!

- How can I find out what I will pay for care I am seeking from Dr. Q?

⇐ Very hard to certain the doctor is in network and the price data corresponds to seeing Dr. Q in that particular network

Navigating online provider directories – much has to go right to get an accurate answer

The consumer must:

- Find the insurer's website
- Find the correct market segment (individual, Medicare, employer-sponsored)
  - Often there are separate websites for each market segment (see example 1)
- Find the provider directory for that market segment
- Find the right network/plan
  - This is very difficult (see example 2), since there is no clear identifier of different provider networks
- Enter the appropriate search terms for a doctor, facility or specialty
  - Choose the right specialty category
    - Not clear what specialty categories mean:
    - If I search for my PCP who is also an OB/GYN, should I search in the "Primary Care" or "Specialist" category?
  - Spell the provider's name correctly
  - Use the name that the carrier has listed for the provider, not another name
    (E.g. can't search for dialysis facility by name because they have many alternate names, must enter "dialysis")
- Figure out what negative results mean
  - If a doctor is not listed in a search, does this mean they are not covered, or does it mean I got any one of the above steps wrong?
  - If so, how do I figure out what to change?

Why Consumers Need to Know the Identify of Their Provider Network

- To benefit from health insurance, consumers must use in-network providers for their care
- Successfully determining if a doctor is covered (or doing so on behalf of someone else) requires a consumer to know the **correct network**.
- For example:

  Consumers are often advised to call their doctor to check if s/he accepts their plan.
  However, asking the doctor's office "Do you accept Blue Cross?"
  (to which the doctor's office will often say "yes")
  does not guarantee that the doctor is in the consumer's particular network.
  This is common with narrower networks such as ACA or Medicare Advantage plans.

Shopping for Care or Plans Requires Knowing the Provider Network

- Consumers are increasingly using apps and online tools to find and research providers – such tools are **essential** for consumers to find and use **higher-quality, lower-cost care**.
- When using tools on availability, cost, and quality of providers and services, knowing whether the provider accepts their insurance coverage is an essential part of deciding on a provider (I found Dr. A+, what would it cost to see her?).
- Consumers in the ACA and Medicare Advantage are expected to shop for plans, including the network.

Problems for Consumers in Identifying Provider Networks

- Networks are not clearly defined or named
  - Some health plan product names names that consumers see correspond to health insurance products at the individual plan level, others to product lines, still others to networks.
  - Health plans names are confusing and similar both within and between carriers, and names are often reused confusingly across different service areas.
  - Product names often incorporate the name the network that the product uses.
- Network names are not uniformly listed with plan information
  - Plan materials such as ID cards may or may not have a network name, which may overlap with the product name
  - Those names don’t match what the options on the website
  - Providers don’t know these network names

Problems for Consumers in Identifying Provider Networks (cont'd)

- Provider directories require a consumer to pick a network by name
  - Often a provider directory page is the first/only time a consumer sees the name of the network itself.
  - Medicaid MCO provider lookups often require discerning which Medicaid program the consumer is in
- Provider information sites (for quality, cost, appointment scheduling, etc.) are hampered by lack of clear identifiers for networks
  - Consumers always want to know if a doctor takes their insurance
  - To deal with the lack of clarity of identify of networks, third party apps/websites may allow consumers to search both plan and network names, which adds ambiguity (see examples 3, 4)

Problems for Consumers in Identifying Provider Networks (cont'd)

- Confusion about provider networks makes it hard for consumers to properly assess and value choices in health plans
  - Network size, composition and geographic extent plays a huge rule in the value of insurance but is effectively impossible for consumers to understand
  - Consumers with particular health needs can face significant barriers to accessing care if they choose a plan that doesn't match their needs.
  - Without any clarity on the relationship between networks and care access, consumers can't possibly assign value these aspects of plans relative to others (e.g. lower premiums, lower deductibles, etc.)

Proposal

- Create a centralized registry or other mechanism to enumerate all provider networks under public regulation
  - Individual and small group market
  - Medicare Advantage
  - Medicaid MCOs
  - Plus any other insurers that will cooperate
- Create a standardized network identifier for each network in the registry
  - Carriers would provide standardize information on each network, including a standard marketing name
  - Carriers could also self-enumerate, and make network information available through a discovery resource (broadly, like the ACA JSON files work now)
- Make identifiers visible on plan documents and apps/websites
  - Insurers could display the network ID on insurance cards, online provider directories, marketing materials, etc.
  - Consumers could use the network ID to go directly to the correct provider directory for their network - without knowing any other information (example 5).

How it would work for consumers

- Your card and other plan materials would have a network ID and a QR code on it
- The QR code would bypass the insurers website and take you straight to the search page of the correct provider directory
- When you call the doctor you could say “do you take network 15BSS44”?

Benefits of this Proposal

- Clarify a provider's in-network status for consumers, plus insurers and others
- A network is simpler to understand because:
  - The network as an entity doesn't usually change from year to year (although individual providers enter and exit)
  - Individual health insurance plans are also not uniformly enumerated and they do change (i.e. new, discontinued plans are common, commercial plans have no uniform identifiers, etc.)
- Sharing a network identifier reveals less about a user than a plan id
- Carrier provider directories and other materials could be simplified using well-defined and standardized identifier.

Benefits – Advance Price Transparency

- Most consumers will need to use tools to make use of price transparency info in advance of their medical care
- Given the complexity of the subject, consumers will be best served a robust ecosystem of third-party apps and tools to help
- To make use of any price information, consumers must know which network their provider is in
- A network ID can also greatly simplify posting of machine-readable files with price data
  - Reduces obfuscation by plan ids (e.g. 14 digit HIOS IDs) that can be started/discontinued/reassigned from year to year
  - Also can significantly reduce the volume of data to be posted and transferred in machine-readable files
  - Simplifies year-to-year versioning of data

Benefits - Advance Price Transparency (cont'd)

- For consumers to benefit from price transparency the ability to correctly look up provider network participation must straightforward, unambiguous, and accessible via third-party apps
- Consumer experience is profoundly dependent on the network the consumer is in
  - Publicly reported quality data (e.g. CAHPS, HEDIS) could collect, analyze, and report on network-specific consumer experience
- Consumers asserting their rights against surprise billing or Advanced EOBs under the No Surprises Act also need to know their network

Benefits - Provider Verification of their Network Participation

- Providers could use a network identifier to declare their own participation
  - Providers are the ultimate authority on the network they are in and first to know when they will enter or leave a network
  - Reduce ambiguity of “We accept United and Aetna” when a patient calls the doctor’s office (often the doctor does not participate in narrower networks like ACA or Medicare advantage networks)
  - Carriers and other third parties could improve provider directory accuracy via reconciliation
  - Consumer-friendly price transparency for outpatient care requires solving provider directory problem (i.e., what’s the contracted rate?)

Benefits – Insurers Can Market Their Networks

- Carriers invest heavily in their networks:
  - Measuring outcomes and quality of contracted providers
  - Increasing coordination and in-network retention
  - Meeting network adequacy requirements
  - Facilitating data exchange for claims processing and care coordination
- Pricing of plans in exchange environments (public, private, Medicare Advantage, Medicaid MCO, FEHB etc.) is strongly related to the breadth and quality of the network
- Identifying networks could dramatically clarify the value proposition for consumers

Benefits - Interoperability

- A simple identifier is needed to enabling unambiguous answers from provider directories via API (machine-to-machine, for apps etc)
  - A definitive answer is possible with network ID + NPI
  - Some carriers' FHIR implementations are currently using network/planIDs as inputs, others use plans as outputs; this will hinder true interoperability.
- A network ID complements CMS & HHS' final rules to require carriers to make provider network data more accessible
  - Data can refer to network instead of plans
    (plans are listed in ACA Marketplace JSON files but this approach has significant drawbacks)
  - Providers can check their own participation against carrier websites

Implementation Considerations

- Network identifiers are currently collected for individual and small group markets
  - SERFF submissions include network ids but these are only consistent within an individual submission (i.e. SERFF binder)
  - NAIC SERFF system could be easily adapted to make these IDs unique across all binders and carriers.
- Networks for Medicare Advantage Plans are individually evaluated for network adequacy by CMS
  - Submissions could be adapted to provide a network identifier
- Consumer network identifier DOES NOT need to match a carrier's internal identifier(s) for that network – merely produce the same results as choosing the and searching correct provider directory.
- NPPES could be a good candidate for this enumeration
  - Experience in enumeration and publishing identifiers

Potential Legal Authority

- Federal: such enumeration falls clearly under the legal authority of US code 42§1320d-2 that authorizes NPPES
  - Regulation or rulemaking might be needed
- State insurance regulators and CMS have existing authority to collect information on networks; could build on this to begin enumeration
  - E.g. extend requirements on submission of Essential Community Providers
  - Could also use authority under review of forms and other consumer materials
- CMS Final Rules claim authority to require disclosure or price data
- Data on ACA networks, including identifiers, is already shared in the CCIIO Marketplace PUF files

Ideas? Want to advance this?

Contact:

Eric Ellsworth

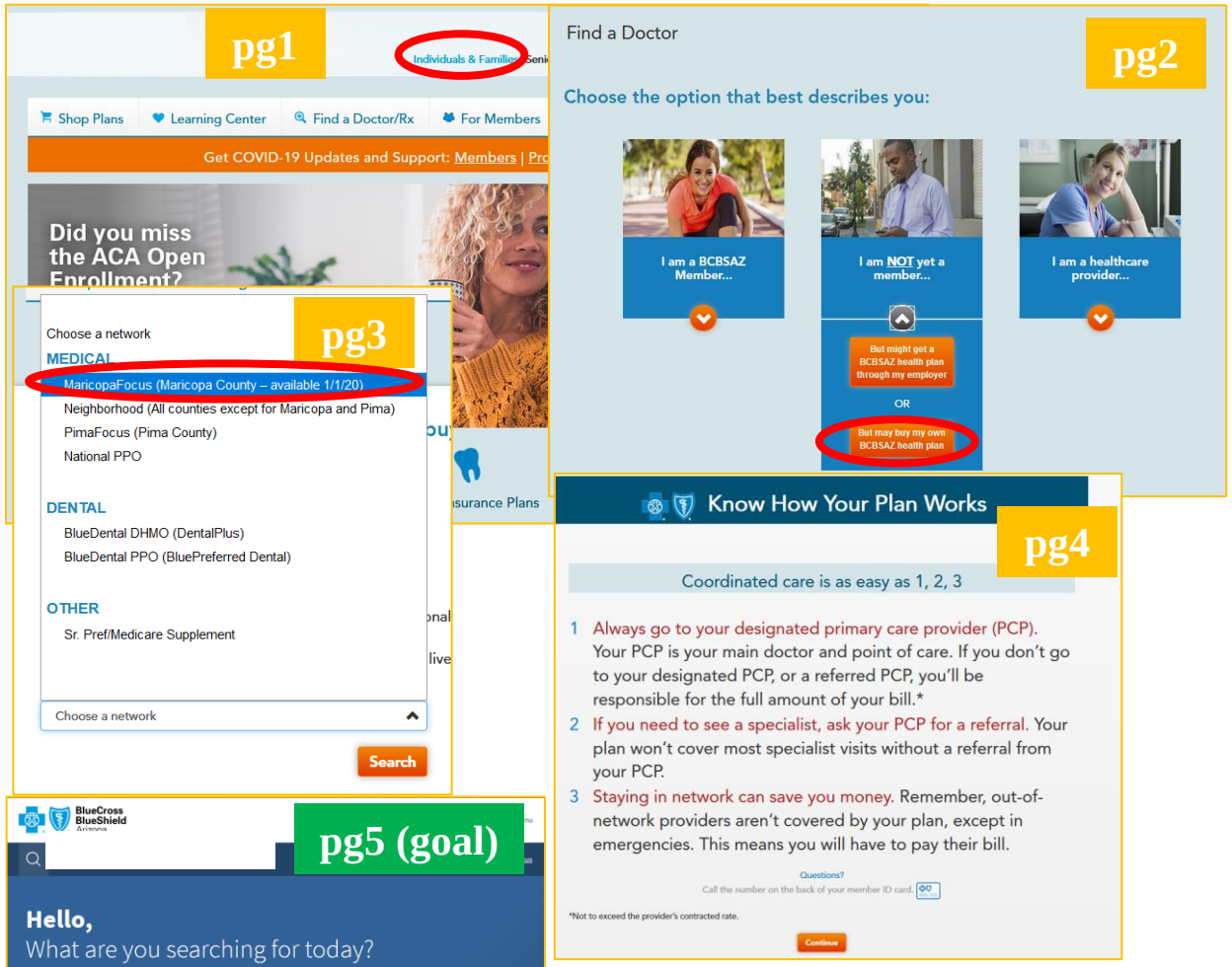
Director, Health Data Strategy

eellsworth@checkbook.org

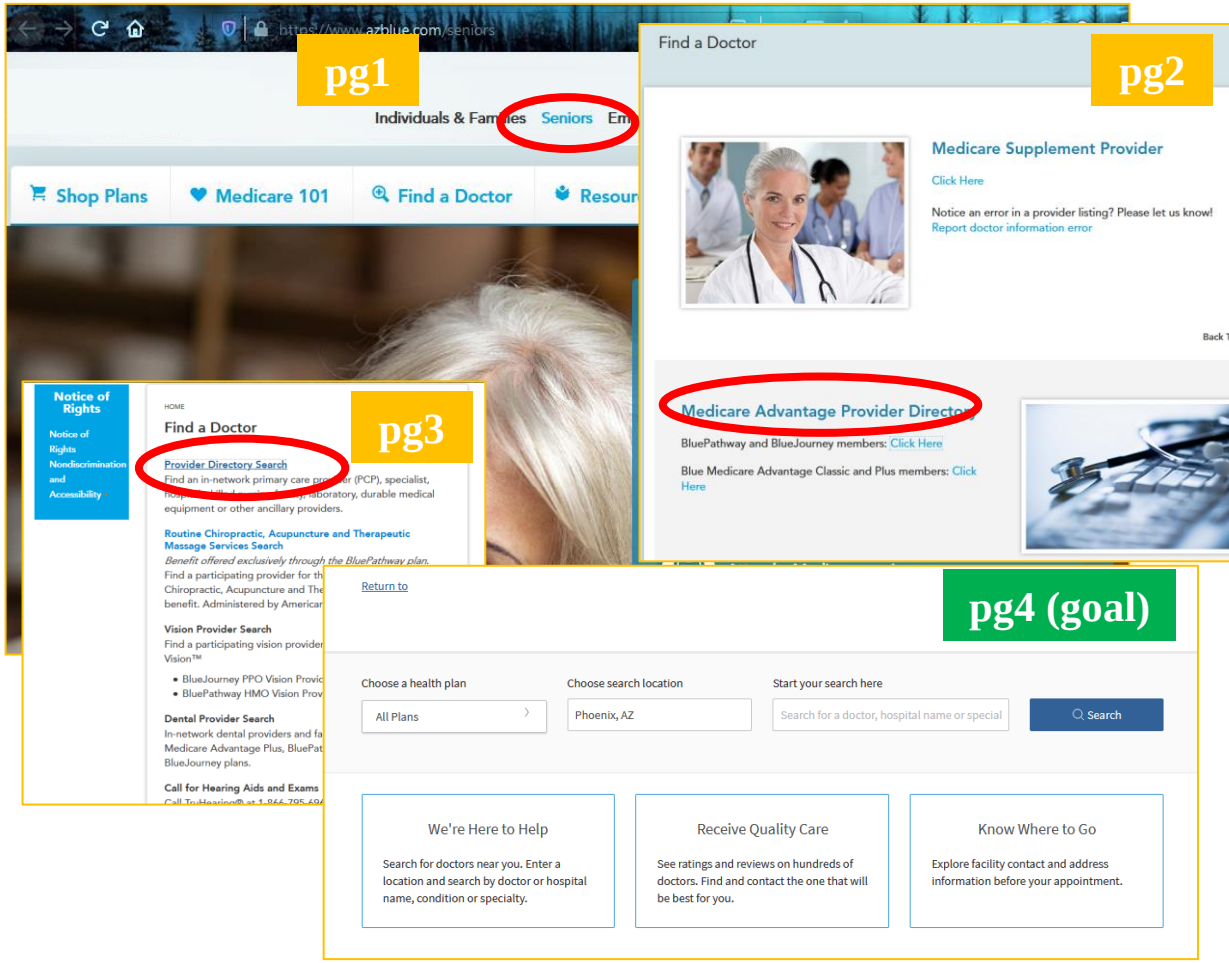
412-600-0762

Example 1 – Reaching the right provider directory is hard!

ACA Plans (aka "Individuals and Families")



Medicare Advantage (aka "Seniors")

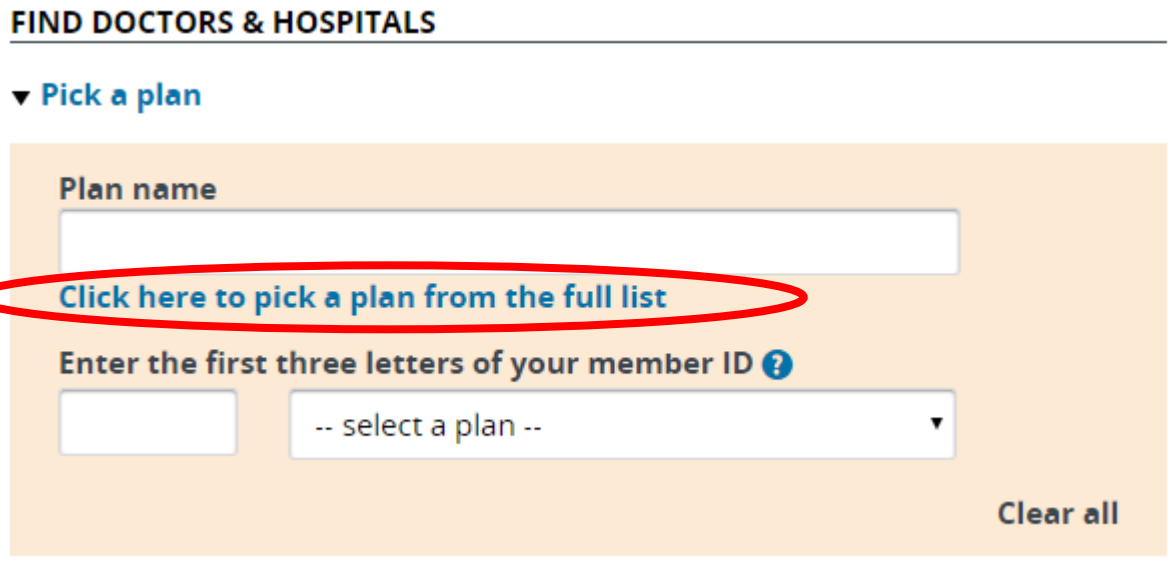


To find the right provider directory, a consumer must discern the right place to click from among numerous alternatives and unfamiliar terms, over several complex pages. If the person doesn't get it right they will get wrong info about coverage of providers.

Example 2

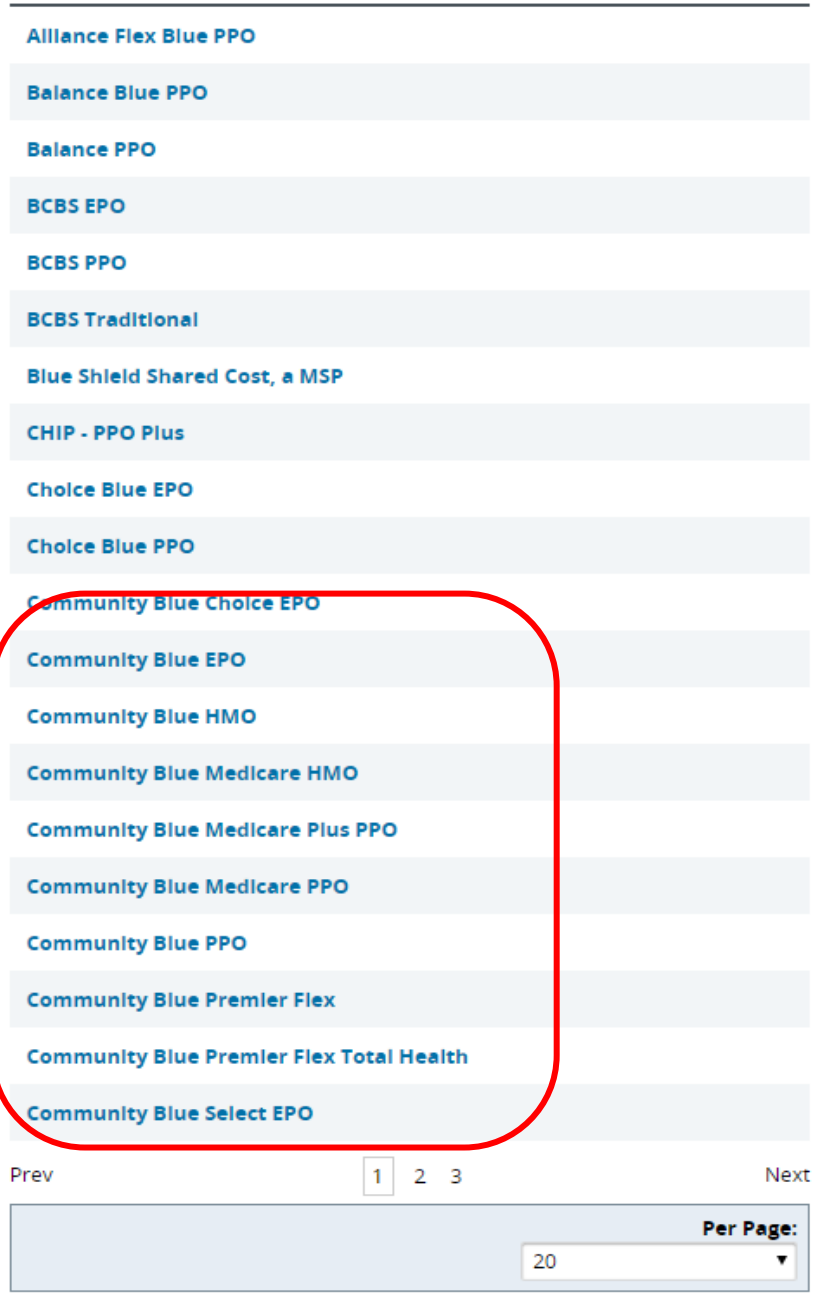
Online Provider Directory

1)

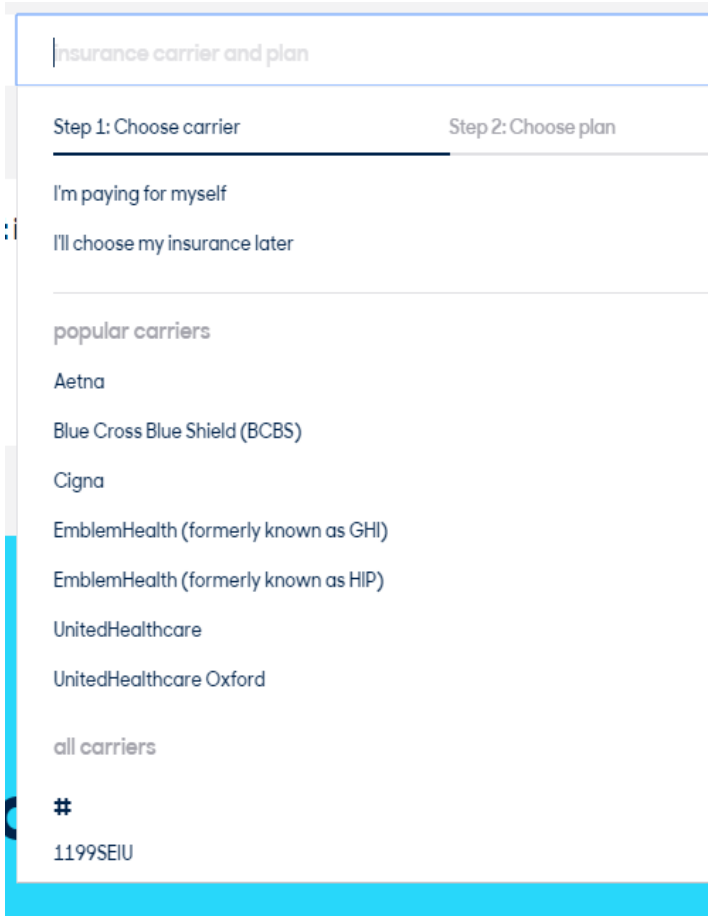


Plan/Product/ Network (which are these?) names are very similar to one another, with unclear relationship to the name of the consumer's own plan

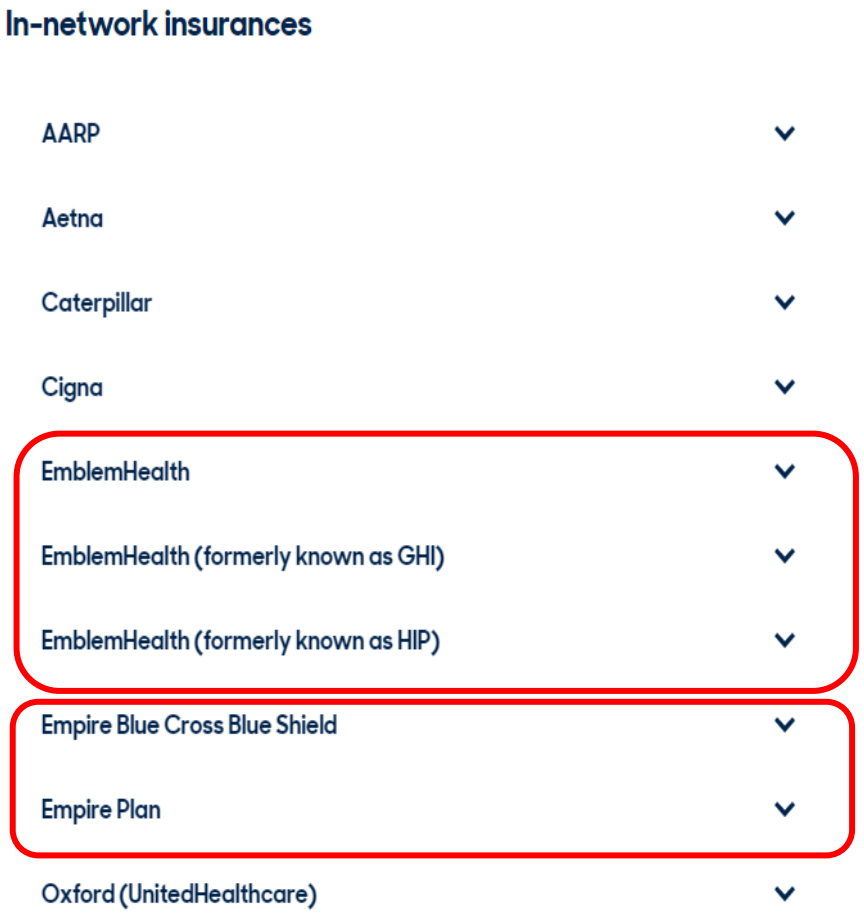
2)



Example 3 - Appointment Scheduling Site

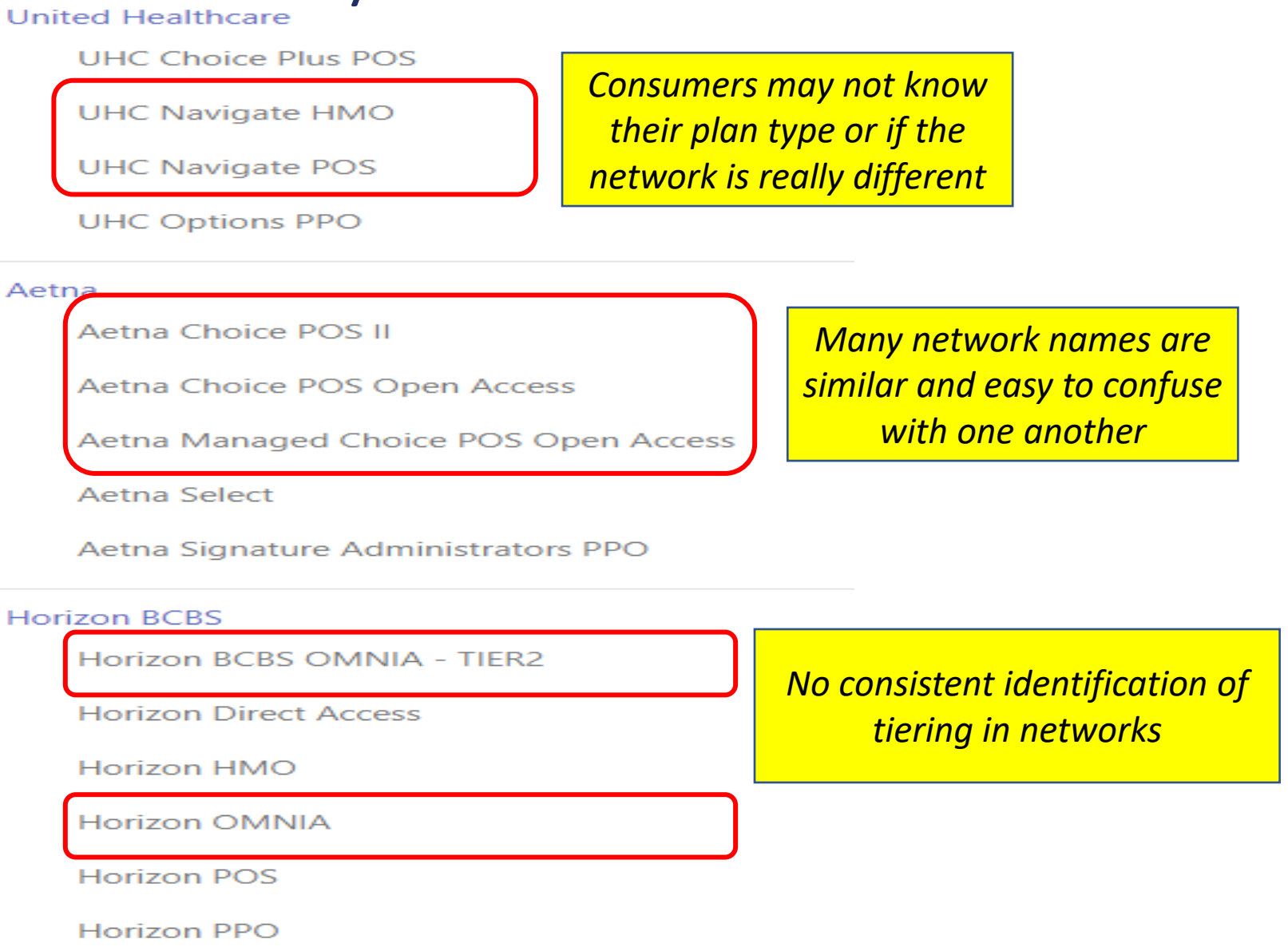


Many network names are similar and easy to confuse with one another



Insurance company names are also displayed instead of networks but are also easily confused

Example 4 – Provider Quality Site



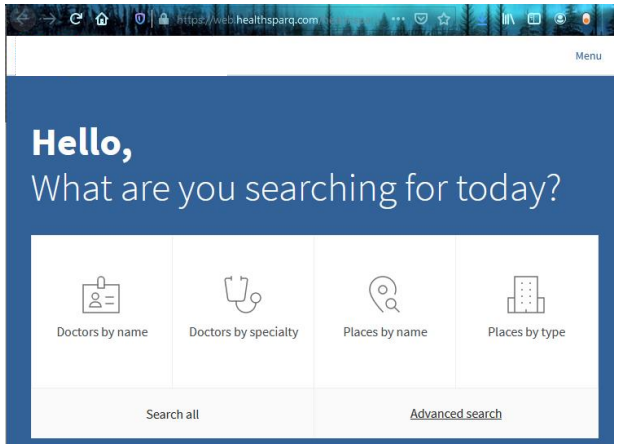
Example 5 – A network ID would dramatically simplify provider directory searches

Scan or type the code

29HCP13

Skip confusing site navigation and difficult questions about where to search

Go straight to searching the right provider directory



Third party sites could show network IDs – or allow users to enter them.