



Transparency in Coverage

External Frequently Asked Questions

5/10/21

United
Healthcare

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Resources

External - these are publicly available or UHG information posted on [uhc.com](https://www.uhc.com).

CMS Transparency in Coverage [Final Rule Fact Sheet](#)

[List of the 500 items and services in the 2023 tool](#)

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Transparency in Coverage Overview

What are the key elements of the Transparency Rule? **Update 4/14/21**

On November 12, 2020, the Departments of Health and Human Services, Labor and the Treasury finalized the Transparency in Coverage Rule that requires health insurers and group health plans to create a member-facing price comparison tool and post publicly available machine-readable files that include in-network negotiated payment rates and historical out-of-network charges for covered items and services, including prescription drugs. Data in machine-readable files must be updated monthly.

- **Publicly Available Machine-Readable Files:** Insurers and plans will be required to make available to the public — including consumers, researchers, employers, and third-party developers — machine-readable files disclosing detailed information on the costs of covered items and services including prescription drug pricing, as follows:
 1. Negotiated rates for in-network providers
 2. Historical allowed amounts and billed charges for out-of-network providers; and
 3. Negotiated rates and historic net prices for prescription drugs

- **Member Price Comparison Tool:**

The Transparency in Coverage rule requires insurers and plans to create online consumer tools that include personalized information regarding members' cost-sharing responsibilities for covered items and services, including prescription drugs. The tool must be an internet-based cost estimator tool to estimate personal cost-share liability for both medical and prescription drugs.

The tools must:

- Permit members to search based on billing code or description
- Allow members to compare costs across both in-network and out-of-network providers
- Inform members of any accumulated deductible or other out-of-pocket expenditures to date
- List any factors that impact the cost such as service location or drug dosage
- Provide cost estimates in paper format at the member's request

Beginning with plan years on or after January 1, 2023, the cost estimator tool must disclose information on 500 items, services and prescription drugs identified in the final rule. Starting with plan years on and after January 1, 2024, the tool must list all covered items and services including prescription drugs.

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What is the effective date for compliance with the Rule? **New 4/8/21**

Publicly Available Machine-Readable Files: Effective for **plan years on and after January 1, 2022**, insurers and plans must disclose to the public, among other data, negotiated prices and historical net plan allowable amount for all covered items and services including prescription drugs.

Member Price Comparison Tool:

Effective for **plan years beginning on and after January 1, 2023**, insurers and plans must provide members with real-time benefit cost estimator tools that allow members and consumers to understand and compare their personalized out-of-pocket costs for covered in-network and out-of-network services. The price comparison tool must list 500 items, services, and prescriptions drugs identified in the final rule. The list is primarily for medical items and services for January 1, 2023.

Effective for **plan years beginning on and after January 1, 2024**, insurers and plans must provide members with real-time benefit cost estimator tools that provide costs for all covered medical items, services and drugs that allow members and consumers to understand and compare their personalized out-of-pocket costs for in-network and out-of-network services.

Does the rule apply to insurers and group health plans? **New 4/14/21**

Yes. The rule applies directly to health insurers and to group health plans. The health insurer is responsible for implementing the requirements for fully insured group health plans.

A self-funded group health plan may contract with a third-party administrator to implement some or all requirements of the rule on behalf of the plan.

Can insurers support the compliance requirements for a group health plan? **Update 4/14/21**

Yes. While the Transparency in Coverage Rule applies directly to group health plans, an issuer or third-party administrator (TPA) may support the compliance requirements for the group health plan.

Doesn't the rule violate HIPAA or other security or privacy rules? **New 4/8/21**

No. The Transparency Final Rule did not alter existing state and federal privacy or security requirements, including the requirements under the Health Insurance Portability and Accountability Act (HIPAA). The transparency final rule does not require the public disclosure of protected personal health information (PHI).

How will the Transparency Rule be enforced? **New 4/8/21**

Insured plans — for the most part states have the primary enforcement authority. The Department of Health and Human Services (HHS) will enforce the rule if a state fails to do so.

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ERISA plans — the Department of Labor (DOL) has primary enforcement authority over group health plans subject to ERISA.

Do the machine-readable files need to directly relate to the shoppable items and services in the price comparison tool? New 4/8/21

No. There is no requirement in the rule that a crosswalk is required between the data displayed in the machine-readable files and the price comparison tool because the price comparison tool is member specific.

Scope - What's included or not

Who is in scope for compliance with the Rule? New 4/8/21

The Transparency in Coverage Rule applies to health insurers in the individual and group markets and to group health plans. Exchange plans and Transitional Relief plans (sometimes called “grandmother” coverage) plans are also included. The rule does not apply to grandfathered plans, excepted benefit plans and short-term limited durations plans.

What is a grandfathered plan or a Transitional Relief plan? New 4/8/21

Grandfathered plans are those that were in place prior to the March 23, 2010 enactment of the Affordable Care Act (ACA). Grandfathered plans are exempt from many ACA requirements provided no significant changes are made to the plan design. A health plan must disclose whether it considers itself a grandfathered plan.

Transitional Relief plans became effective after the ACA enactment and do not comply with certain ACA provisions. Federal regulators have allowed these plans to renew under a non-enforcement policy on an annual basis if the plan is otherwise permitted by state law.

What health plans are not covered under the Transparency Rule? New 4/8/21

The following plans are not covered under the rule:

- Grandfathered plans
- Excepted benefits (e.g., standalone vision, dental, and hearing plans)
- Retiree only plans
- Short term limited duration (STLD) plans
- Flexible Spending Accounts (FSA), Health Reimbursement Accounts (HRA) and Health Savings Accounts (HSA)
- Medicare
- Medicaid

Customers should consult their own counsel on whether a plan is not covered.

Note: the rule does apply to Transitional Relief plans.

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When dental or vision are integrated with the medical plan, would they be included in the machine-readable file requirement? New 4/8/21

Yes.

While the rule does not apply to excepted benefits such as standalone dental or vision coverage, if those benefits are integrated with the medical plan, they would be subject to the rule.

Are non-ERISA self-funded plans included in the Transparency Rule requirements? New 4/8/21

Yes, subject to potential government immunities, non-ERISA self-funded plans are impacted and must meet the requirements for both machine-readable files and price comparison tool. Clients should always discuss the issue with their legal counsel.

Are tribal plans included in the Transparency Rule requirements? New 4/8/21

Yes, subject to potential sovereign government immunity, if a tribe's health plan is organized under the Employee Retirement Income Security Act (ERISA) or the Public Health Services Act (PHSA), the tribal plan would be subject to transparency requirements. Clients should always discuss the issue with their legal counsel.

Does information from secondary networks need to be included in the in-network machine-readable file? New 4/8/21

It depends on how the provider is classified and priced for the plan - in-network or out-of-network. If the secondary network providers are considered in-network, their rates should be included in the in-network file.

If a CRS or other out-of-network vendor negotiates a rate is this considered out-of-network and would it be part of out-of-network file? New 4/8/21

It depends on how the provider is classified and priced for the plan - in-network or out-of-network. If CRS or other network vendor negotiates rates that are considered in-network, their rates should be included in the in-network file.

Are UnitedHealthcare Global Solutions expatriate health insurance plans in scope? New 4/8/21

No. Expatriate plans are not included in the Transparency Rule requirements.

Are UnitedHealthcare Global Solutions business travel plans in scope? New 4/8/21

No. Business travel insurance is an excepted benefit and therefore not included.

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Publicly Available Machine-Readable Files

When are the machine-readable files required to be available? **New 4/8/21**

These files are required to be made public for plan years that begin on or after January 1, 2022.

What are the requirements for January 1, 2022? **New 4/8/21**

Each insurer/health plan must provide three separate machine-readable files that include detailed pricing information. These files must be available at no cost and be updated monthly. The files must also include billing codes used to identify the item or service such as the Current Procedural Terminology (CPT) code, Health Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code or the National Drug Code (NDC) or other common identifiers.

File One - In-Network Rates. Must show negotiated rates for all covered in-network items and services.

File Two - Out-of-Network Historical Rates. Must show both the historical payments to, and billed charges from, out-of-network providers for all covered items, services, and prescription drugs. Data does not have to be reported if the provider has fewer than 20 claims for the item or service during the reporting period.

File Three - Prescription Drugs. Must detail the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

The historical prices are for the 90-day time-period that begins 180 days prior to the file publication date.

How must the data be displayed? **Update 4/14/21**

Data files must be displayed in a standardized format and must be updated monthly.

Based on the technical guidance issued by the Centers for Medicare and Medicaid Services (CMS), we know that the file CAN NOT be a PDF or Excel document.

Who may use the data and for what purpose? **New 4/8/21**

Third-party use of the data in the machine-readable files is not controlled by UnitedHealthcare.

Will we charge customers for creating the machine-readable files? **New 4/8/21**

UnitedHealthcare will create machine-readable files for all fully insured plan as designated under the Transparency in Coverage Rule.

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For self-funded customers using a UnitedHealthcare network will create machine-readable files as designated under the Transparency in Coverage Rule. Any additional administrative costs are yet to be determined.

For self-funded customers where UnitedHealthcare processes the claims and provides a customer specific network, UnitedHealthcare will post the files. Any additional administrative costs are yet to be determined.

For self-funded customers that have plans with custom networks, please discuss your needs related to compliance with the final Transparency in Coverage rule with your UnitedHealthcare representative. These requests will be considered on a case by case basis.

Self-funded customers can expect timely and relevant information regarding potential administrative costs as more details become available.

Does anyone wanting to access the machine-readable file have to open a user account?

New 4/8

No. Files must be accessible free of charge, without having to establish a user account, password, or other credentials, and without having to submit any personal identifying information such as a name, email address, or telephone number.

How should prescription drugs be reported? Update 4/14/21

Covered prescription drugs that are purchased on in-network basis should be included in the Prescription Drug File.

Covered prescription drugs that are purchased out-of-network should be included in the out-of-network machine-readable file.

The Prescription Drug data should include:

- strength, dosage, and formulation level at the first 9-digit NDC level,
- dollar amount of negotiated rate for each in-network pharmacy,
- the pharmacy tax ID number (TIN), place of service code, NPI, and
- amount the issuer or health plan paid for the prescription drug including any allocated price concessions, rebate, discounts, chargebacks, fees.

What support is available for customers with a PBM other than OptumRx? Update 4/14/21

If other PBM networks would like UnitedHealthcare to post machine-readable files on their behalf, the customer should discuss this with their UnitedHealthcare representative. These requests would be considered on a case by case basis. Self-funded customers can expect timely and relevant information regarding potential administrative costs as more details become available.

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Price Comparison Tools for Members

What must be included in the price comparison tool? **New 4/8/21**

The tool must make available to participants, beneficiaries and enrollees or their authorized representative personalized out-of-pocket cost information as well as the underlying negotiated rates for all covered health care items and services including prescription drugs. The information must be available through an internet-based self-service tool and if requested in paper form.

Most consumers will be able to get real-time and accurate estimates of their cost-sharing liability for health care items and services from different providers. The tool requirements may allow the members to:

- Understand how costs for covered health care items and services are determined by their plan, and
- Shop and compare health care costs before receiving care.

What is the timing for the tool to have available services? **New 4/8/21**

Starting with plan years beginning on or after January 1, 2023, insurers and plans must make the cost-estimator tool available for 500 shoppable items, services and drugs identified in the rule. For the first year, most of these required services are medical.

All covered items, services, and drugs will be required to be included in the price comparison tools for plan years that begin on or after January 1, 2024.

What is meant by all items and services? **New 4/8/21**

Beginning on and after January 1, 2024, the disclosure requirement for the cost comparison tool expands to all medical care covered by the insurer or plan including charges in connection with office visits, virtual care, medical tests, durable medical equipment, and prescription drugs.

What are the search capabilities in the price comparison tool? **New 4/8/21**

Information will be available at no cost either through an internet self-service tool or can be mailed/emailed to a member who requests estimates in writing.

Members must be able to search for covered items and services by:

- Billing code or descriptive term (e.g., rapid flu test),
- Provider/pharmacy name, and
- Other factors relevant to determine cost sharing (e.g., facility name, service location, network, tiering, dosage).

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The member can adjust their search or prioritize the results based on geographic proximity of providers and the estimated cost share liability for the item/services/drug if there are multiple results.

What are the benefits of the price comparison tools? Update 4/14/21

According to the federal agencies, the transparency in coverage requirements may provide the following consumer benefits:

- Enables consumers to evaluate health care options and to make cost-conscious decisions.
- Strengthens the support consumers receive from stakeholders that help protect and engage consumers.
- Reduces potential surprises in relation to individual members' out-of-pocket costs for health care services.
- Creates a competition that may narrow price dispersion for the same items and services in the same health care markets.
- Potentially lowers overall health care costs.

UnitedHealthcare provides these types of transparency tools to members to support the member optimizing their benefits and help the member to access lower cost, more affordable health care services.

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Disclosure Requirements

What information must be provided to the members in the health plan? **New 4/8/21**

Beginning with plan years on and after 1/1/2023, issuers and self-funded plans are required to provide members with the following information.

- An estimate of cost share responsibility: The member's cost share for an item or service covered under the plan.
- Accumulated amounts: Any accrued deductible or out of pocket payment amount including the items and services that accrued under the plan.
- Negotiated rates: based on network provider payments for items and services.
- Out-of-network allowed amount: max a plan would pay and out-of-network provider for a covered item or service.
- Content list of items and services: for bundled services a list of each covered item and service plus the costs for bundled services.
- Notice of prerequisites to coverage: health plans must inform the member if an item or service is subject to medical management requirements including prior authorization, concurrent review, step therapy.
- Disclosure notice that the tool is providing an estimate and that actual costs may vary.

What is required in the disclosure notice? **New 4/8/21**

The issuer and the self-funded health plan must provide the following disclosures in plain language:

- Information disclosing that out-of-network providers may balance bill the individual member for the difference between what the provider billed and the member's cost share amount (copayment, deductible or coinsurance) if and when balance billing is permitted under state or federal law.
- A statement that the actual charge may be different from the estimate.
- A statement that the cost share estimate is not a guarantee of coverage.
- Information on whether the copay counts toward the deductible and the out-of-pocket max.

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UnitedHealthcare Approach

Will UnitedHealthcare support the transparency rule requirements? Update 4/9/21

UnitedHealth Group is committed to compliance with the laws and regulations applicable to our business and intends to comply with the requirements of the rules.

UnitedHealth Group has long supported actionable price and quality transparency for consumers and currently offers transparency tools to a significant portion of our business.

To prepare for the new Transparency in Coverage rule, UnitedHealthcare is working to ensure a price transparency tool and machine-readable rate files are available for all UnitedHealthcare platforms, pricing structures, and plan designs for individuals and their authorized representatives at the appropriate time.

Is UnitedHealthcare prepared to support customer compliance with the new law? Update 4/14/21

Yes. UnitedHealthcare will support customers in complying with the new rule.

Self-funded customers that have plans with custom networks should discuss their needs related to compliance with the final Transparency in Coverage rule with their UnitedHealthcare representative. These requests will be considered on a case by case basis.

Self-funded customers can expect timely and relevant information regarding potential administrative costs as more details become available.

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Self-funded Customer Support

Update 5/10/21

UnitedHealthcare is committed to helping customers comply with the new rule.

UnitedHealthcare will create, generate, and publish three machine-readable files for our customers including self-funded customers. These will be available on a publicly available website effective Jan. 1, 2022 and monthly thereafter.

Self-funded customers that have plans with custom networks should discuss their needs related to compliance with the final Transparency in Coverage rule with their UnitedHealthcare representative. These requests will be considered on a case by case basis.

We are gathering information from customers on what their needs are and will update FAQs as options are available over the upcoming weeks.

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Pharmacy Approach for Integrated Pharmacy

What are the requirements for prescription drugs? **New 4/8/21**

The Rule includes requirements for prescription drugs for both the Machine-Readable Files and the Member Price Comparison Tool.

Publicly Available Machine-Readable Files: Plans will be required to make available to the public without password protection, including consumers, researchers, employers, and third-party developers, machine-readable files disclosing detailed drug pricing. For drugs, this means payment rates to in-network pharmacies and historical net prices including rebates.

The Rule requires the machine-readable file to include the “Average Historical Net Price” which is an aggregation of what could be multiple price points over time, and the “Negotiated Price” which is OptumRx’s contractual agreement with pharmacies.

The file must be updated monthly for each plan each client offers that includes negotiated pharmacy rates.

The prescription drug files must be provided for each plan offered by each client that includes the applicable negotiated pharmacy rate in effect for the current pharmacy contract period, and data for the 90-day period beginning 180 days before the file publication date with plan net paid amount (i.e., inclusive of rebates, discounts, chargebacks, fees, and other price concessions) for each contracted pharmacy by NDC.

Member Price Comparison Tool: Plans will be required to offer an Internet-based cost estimator tool to estimate personal cost-share liability for both medical and Rx drugs. The tool must include the pharmacy’s negotiated rate with OptumRx at varied drug dosage levels including designs that may be applicable to the member (e.g., accumulators, in-network/OON, Prior Authorization, Step Therapy).

The member facing price comparison tool is required to have member out-of-pocket cost sharing, member accumulated deductibles or out-of-pockets, pharmacy negotiated rates, and allowed amounts for each drug for each pharmacy within the network.

By 1/1/2023, a subset of 500 services are required; almost all of which are medical and not applicable to prescription drugs. By 1/1/2024, the tool must list all services including prescription drugs.

How will UHC support its clients with compliance to the prescription drug components of the Rule? **Update 4/14**

UnitedHealthcare is partnering closely with OptumRx to ensure readiness to support compliance with both components of the Rule.

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OptumRx Support for Direct Pharmacy (Carve-out) customers

Will OptumRx support clients with the machine-readable reporting and data posting requirements? **New 4/8/21**

Yes. OptumRx will support our clients with creation of machine-readable files. We are working on our approach to file generation and how to most efficiently scale the reporting given the number of clients and volume of plans we support.

OptumRx is currently proposing three different service levels to support clients with their compliance with the Rule as summarized below.

Basic:

- Collation of Client data with OptumRx data
- Aggregate the data into the required layout per Appendix 4 requirements
- Audit and data quality check
- Provide data dictionary
- Send file to client (txt/ CSV file)

Advanced:

- Collation of Client data with OptumRx data
- Aggregate the data into the required layout per Appendix 4 requirements
- Audit and data quality check
- Provide data dictionary
- Data is converted to a machine-readable format (JSON file)
- Client is responsible to display

Premium: End to end solution includes:

- Collation of Client data with OptumRx data
- Aggregate the data into the required layout per Appendix 4 requirements
- Audit and provide quality check
- Provide data dictionary
- OptumRx creates Machine readable data and hosts data under client specific URL
- OptumRx is highlighted as “Name of Reporting Entity” on file and will receive and respond to questions
- Provide client with display URL for their portals
- Maintain and publish the monthly updates

What if my client wants services outside of the standard service levels OptumRx is offering? Are we able to customize our approach? **Update 4/14/21**

OptumRx may be able to accommodate certain levels of customization for select large employers and health plan clients. Talk to your Optum customer service representative.

If a client engages with a third party (such as a data warehouse or health care pricing vendor for enrolled members) to ensure compliance with the federal requirements, will your organization provide all necessary data elements to the third party? **Update 4/14/21**

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Yes, OptumRx can provide the data with an appropriate NDA. OptumRx may charge additional fees. In this situation, OptumRx would provide the following services.

Basic Service Option:

- Summarize the data
- Audit and provide quality check
- Provide data dictionary
- Client sends OptumRx EIN crosswalk
- Send file to client (CSV file) for conversion to machine-readable format and display

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