MY BENEFIT ADVISOR

Final Group Health Plan Transparency Rules Issued

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On October 29, 2020, the Departments of Labor, Health and Human Services and the Treasury (collectively, "the Departments") issued the final rule on transparency in health plan coverage. The final rule imposes significant new requirements on non-grandfathered group health plans to disclose information on pricing and cost-sharing under their plans. This latest guidance finalizes proposed regulations issued in 2019.

The final rules adopt a phased-in schedule for compliance beginning with plan years on or after January 1, 2022 and completing with plan years that begin on or after January 1, 2024.

These rules apply to non-grandfathered insured and self-insured major medical plans. They do not apply to:

- excepted benefits (e.g., dental, vision, health FSAs);
- health reimbursement arrangements ("HRAs") and other account-based plans (e.g., individual coverage HRAs, "ICHRAs"); or
- short-term limited duration insurance.

The stated goal of the final rule is to support a market-driven health care system by giving employees and other consumers the information they need to make informed decisions about their health care purchases. For example, the rule provides participants and beneficiaries with price and benefit information in advance of receiving care, which can enable them to evaluate their health care options and make cost-conscious decisions. The Departments are of the view that price transparency will, over time, potentially lower overall health care costs in the market.

Required Disclosures

Like the proposed rule, the final rule adopts two new disclosure requirements:

1. Public disclosure via three machine-readable files of:
   b. in-network provider rates for covered items and services,
   c. out-of-network allowed amounts and billed charges for covered items and services, and
   d. negotiated rates and historical net prices for covered prescription drugs.

2. Disclosure of cost-sharing information to participants and beneficiaries through an internet-based self-service tool or paper format (upon request).

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Public Disclosure

Effective for plan years beginning on or after January 1, 2022, group health plans must disclose in-network provider negotiated rates, historical out-of-network allowed amounts, and drug pricing information through three machine-readable files posted on an internet website, thereby allowing the public access to health coverage information that can be used to understand health care pricing and potentially dampen the rise in health care spending. These files must be accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

In a change from the proposed rule, the final rule adopts a third machine readable file specifically for prescription drug pricing information which will include the negotiated rate and the historical net price.

Machine-readable files and the information required by the final rule must be updated monthly and the date the files were most recently updated should be clearly indicated.

In connection with the proposed rule, the Departments issued data elements for these machine-readable files. The Departments are likely to update these files for the final rule and provide a third set of data elements to reflect the new prescription drug file.

Disclosures to Participants and Beneficiaries

Group health plans must disclose upon the request of a participant or beneficiary who is enrolled in a group health plan (or their authorized representative) cost-sharing information including an estimate of the individual's cost-sharing liability for covered items or services furnished by a provider.

This disclosure is similar to an explanation of benefits ("EOB"), except that it is provided before medical treatment, not afterwards. This information should be made available on an internet website and, if requested, in paper form, thereby allowing the requesting party to obtain an estimate and better understand the individual's out-of-pocket expenses. This should allow users to more effectively shop for items and services before deciding on a provider.

Briefly, the following cost-sharing information must be disclosed. The information should be accurate as of the time the request is made.

- Estimated cost sharing. An estimate of the participant's or beneficiary's cost-sharing liability at the time the request is made, considering all deductibles, coinsurance, copayments and other cost-sharing provisions under the group health plan.

- Accumulated amounts. Accumulated amounts of cost-sharing that the participant or beneficiary has already incurred under the plan at the time the request is made. This would include a current statement of how much the participant has already paid toward their deductible and out-of-pocket limit.

- In-network rate negotiated rates. The plan would need to disclose the dollar amount they have agreed to pay in-network providers for a certain service or prescription drug.

- Out-of-network allowed amounts. The plan must provide the maximum amount that could be paid by the plan for a particular service or drug that is out-of-network.

- Items and services in bundled payment arrangements (if applicable). Cost sharing information for each item and each service within the bundle must be disclosed.

- Any coverage prerequisites (e.g., prior authorization or step therapy) before a participant can receive a service or item.

- Disclosure notice (model notice available) that includes definitions of key terms, disclaimers related to billed charges versus estimated charges, a reminder that balance billing is not included in cost estimates, and contact information for participant questions.

The final rule adopts a phased in approach to compliance:

- With respect to 500 items and services identified by the Departments, compliance is required for plan years beginning on or after January 1, 2023. The final rule lists out the 500 items and services to be provided by 2023 (along with a plain language description and CPT code). This list will be posted on a publicly available website. For now, the list may be found in the preamble to the final regulations, pages 90-116 (linked below).

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- Full compliance is required for plan years beginning on or after January 1, 2024 (includes all items and services – not just the identified 500).

Who is Responsible for Compliance?

Generally, the plan sponsor is responsible for compliance with the final rules.

However, for a fully insured group health plan, the plan and carrier may enter into a written agreement where the carrier agrees to provide the disclosure information under this final rule. In this case, if the carrier fails to provide full or timely information, then the carrier but not the plan, has violated the transparency disclosure requirements.

Similar relief is not available to self-insured group health plans. While a self-insured health plan may contract with a third party to provide the required disclosure, the plan is ultimately responsible.

Employers sponsoring self-insured group health plans will need to ensure their third party administrators ("TPAs") or other vendors (e.g., Pharmacy Benefit Managers, "PBMs") can comply with the disclosure requirements under the final rule and should consider adding indemnification provisions to any service agreement in the event the third party fails to make timely or full disclosures.

The Departments adopt a good faith safe harbor for when a plan or carrier, acting in good faith, makes an error or omission so long as it corrects the information as soon as possible.

Employer Action

This summary provides a high-level overview of the very detailed final rule on the new transparency disclosure requirements. As the various deadlines related to the phased-in approach draw closer, employers should work with their insurance carriers and TPAs to ensure they can comply with these new requirements. This is particularly important if a self-funded plan uses TPAs or other carve-out vendors that are not otherwise affected by these rules as the plan is responsible for compliance.

Resources

- Final Rule: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf
- Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f
- Tables outlining data elements required for each readable file (prescription drug file not available)
  - Negotiated Rate File: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-negotiated-rate-file.pdf
  - Allowed Amounts File: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-allowed-amounts-file.pdf
- Draft Model Disclosure: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-draft-model-disclosure.pdf

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