Agencies Issue Final Employer Healthcare Price Transparency Rule

A Practical Guidance® Article by
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On October 29, 2020, the U.S. Departments of Health and Human Services, Labor and Treasury (collectively, the Departments) issued the Transparency in Coverage final rule (the Rule), along with a fact sheet, setting forth requirements for group health plans and health insurance issuers to disclose cost-sharing information upon request to participants, as well as additional pricing information to the general public. 85 Fed. Reg. 72,158 (Nov. 12, 2020). The Rule is the result of the president's executive order on healthcare price transparency, issued in June 2019, and it follows the Hospital Price Transparency final rule, issued in November 2019. 84 Fed. Reg. 65,524 (Nov. 27, 2019). For additional information, please see our *On the Subjects* here and here.

The Rule requires most non-grandfathered group health plans and health insurance issuers to:

1. Upon request, disclose pricing information specific to participants, beneficiaries or enrollees (or their authorized representative) (collectively referred to herein as participants) –and–

2. Provide public disclosures in machine-readable files regarding in-network, out-of-network and prescription drug prices. This article summarizes some of the provisions of the Rule that apply to group health plan sponsors.

In Depth

Required Public Disclosures and NBSP

The Rule mandates that for plan years that begin on or after January 1, 2022, group health plans must disclose online to the general public **three separate files** that include detailed pricing information.

1. **In-network machine-readable file**. This must include, for each coverage option:

- The name and 14-digit Health Insurance Oversight System (HIOS) identifier, or if unavailable, the 5-digit HIOS identifier, or if unavailable, the Employer Identification Number (EIN)

- A billing code (in the case of prescription drugs, a National Drug Code (NDC)) and plain language description for each billing code for each covered item or service under each coverage option –and–
- All applicable rates (e., negotiated rates, underlying fee schedule rates or derived amounts) that are:
    - Reflected as dollar amounts
    - Associated with the National Provider Identifier (NPI), Tax Identification Number (TIN) and Place of Service Code for each in-network provider
    - Associated with the last date of the contract term or expiration date for each provider-specific applicable rate that applies to each covered item or service –and–
    - Featuring a notation where a reimbursement arrangement other than a standard fee-for-service model (e.g., capitation or a bundled arrangement) applies

2. **Out-of-network allowed amount machine-readable file must include**:

- For each coverage option, the name and 14-digit HIOS identifier, or if unavailable, the 5-digit HIOS identifier, or if unavailable, the EIN.
- A billing code (in the case of prescription drugs, an NDC) and plain language description for each billing code for each covered item or service under each coverage option –and–
- Unique out-of-network allowed amounts and billed charges during the 90-day period beginning 180 days prior to publication of the file (to protect consumer privacy, data with fewer than 20 claims for payment must be excluded) (i) reflected as dollar amounts; and (ii) associated with the NPI, TIN and Place of Service Code for each out-of-network provider.

3. **Prescription drug machine-readable file must include**: For each coverage option:

- The name and 14-digit HIOS identifier, or if available, the 5-digit HIOS identifier, or if unavailable, the Employer Identification Number (EIN)
- The NDC, and the proprietary and nonproprietary name assigned to the NDC by the Food and Drug Administration for each prescription drug under each coverage option
- The negotiated rates (i) reflected as dollar amounts; (ii) associated with the NPI, TIN and Place of Service Code for each in-network provider; and (iii) associated with the last date of the contract term or expiration date for each provider-specific negotiated rate that applies to each NDC –and–
- Historical net prices (i) reflected as dollar amounts; (ii) associated with the NPI, TIN and Place of Service Code for each in-network provider; and (iii) associated with the 90-day period beginning 180 days prior to the publication of the file for each provider-specific historical price that applies to each NDC (to protect consumer privacy, data with fewer than 20 claims for payment must be excluded).

The three files must be in a form and manner specified by the Departments and must be publicly available and accessible to any person free of charge and without conditions (e.g., establishing a user account or password), without the submission of personally identifiable information. Plans must update these three data files on a monthly basis and clearly indicate the date on which the files were updated.

Required Participant Disclosures Upon Request

The Rule requires most group health plans to disclose information specific to a covered item or service to participants upon their request. For plan years that begin on or after January 1, 2023, group health plans must disclose the information below regarding an initial list of 500 services, as determined by the Departments.

For plan years that begin on or after January 1, 2024, plans must disclose the information below regarding the remainder of all procedures, drugs, durable medical equipment and any other items or services:

1. **Estimate of the participant's cost-sharing liability** (e.g., deductibles, coinsurance and copayments) for a requested covered item or service.

2. If the requested item or service is a recommended preventive service and the plan cannot determine whether the request is for preventive purposes, **the cost-sharing liability that would apply for nonpreventive services** (or the participant may request cost-sharing information for the specific preventive or non-preventive item or service by including search terms such as "preventive," "non-preventive" or "diagnostic").

3. **Accumulated amounts** that the participant previously incurred toward a deductible or out-of-pocket limit.

4. **In-network rate**, including the following elements, if applicable to the plan:

- **Negotiated rate for an in-network provider** for the requested covered item or service (even if this rate is not used to calculate cost-sharing liability); and
- **Underlying fee schedule rate** for the requested covered item or service, if different than the negotiated rate

5. If the provider is an out-of-network provider, **out-of-network allowed** amount or any other rate that provides a more accurate estimate of the amount the plan will pay for the requested covered item or service.

6. If the requested item or service is part of a bundled payment that includes items or services with separate cost-sharing liability, **information regarding which items or services are included in the bundle** for which cost-sharing information is provided.

7. **Notification** of any applicable prerequisite to coverage

8. **A notice** that includes the following statements in plain language:

- If balance billing is permitted, an out-of-network provider may bill the participant and the cost-sharing information does not include such amounts
- The actual charges may vary from the provided estimates;
- The cost-sharing liability estimate is not a guarantee that benefits will be provided
- Whether the plan counts copayment assistance and other third-party payments in calculating the cost-sharing and out-of-pocket maximum
- Preventive items may not be subject to cost-sharing liability –and–
- Any other information that the plan deems appropriate

Plans must make the foregoing disclosures available in plain language, without a fee, through an accurate self-service tool or website that allows participants to search for cost-sharing information by using:

- A billing code or descriptive term
- The name of an in-network provider, if applicable –and–
- Other relevant factors in determining cost-sharing information (e.g., location of service, facility name or dosage).

Participants should be able to refine and reorder their search results based on proximity of in-network providers and the amount of estimated cost-sharing liability.

At a participant's request, the plan must make the foregoing disclosures available in plain language, without a fee, in paper form (in which case the disclosure may be limited to no fewer than 20 providers per request). The paper form must be mailed to the participant within two business days after receipt of the request. Alternatively, if the participant agrees, the plan may disclose the required information by phone or email.

Group health plans are generally subject to the required public and participant disclosures, but insured plans may require their insurance issuer(s) to provide such disclosures. If such an arrangement is established pursuant to a written agreement, the issuer becomes liable for any violation of the public and participant disclosure requirements of the Rule. Any group health plan subject to the Rule, including self-funded plans, may contract with a third-party administrator to comply with the public and participant disclosures, but the Rule offers no liability shield for self-funded plans.

Practical Application

The Departments stated that in establishing the Rule, they aim to provide ample health insurance data for consumers, researchers and third parties to reduce healthcare costs and promote competition in the health insurance market. However, the Rule will likely receive legal challenges from health insurers arguing that it will undercut their ability to bargain with providers and drug companies. The Departments appear to have anticipated legal challenges to the Rule, as its preamble includes extensive legal justification, relying on legal authority under the Affordable Care Act (ACA). It is unclear how the Rule would survive if the ACA is partially or completely invalidated in ongoing litigation (e.g., *California v. Texas*).

If the Rule withstands legal review, patients and their families could influence the health insurance market in an unprecedented way. To date, patients have often chosen providers based on reputation or recommendations. It remains to be seen how the Rule would affect patient choice, as the Rule does not require disclosure of any provider quality information.

For most employer-sponsored group health plans, we predict that the Rule's disclosure obligations would be met by third-party providers on behalf of a plan. Similar to when ACA reporting vendors began appearing, there will likely be a number of providers purporting to be able to meet these requirements, but some will likely be better suited than others and some ill-equipped. Plan sponsors should

exercise caution when contracting with these providers, to ensure both that they are able to meet the heavy demands of this Rule and that the plan and company are sufficiently indemnified and protected should the provider fall short. In the meantime, group health plan sponsors should monitor legal challenges to the Rule and prepare for the potentially significant burden of complying with the Rule's public disclosure and participant disclosure requirements.

Related Content

Lexis

- 84 Fed. Reg 65,464 (Nov. 27, 2019)(proposed rule on healthcare price transparency)
- 85 Fed. Reg. 72,158 (Nov. 12, 2020)(final rule on healthcare price transparency)
- 3 CFR Executive Order 13951, "An America-First Healthcare Plan"
- ARTICLE: PRICE TRANSPARENCY AND INCOMPLETE CONTRACTS IN HEALTH CARE, 67 Emory L.J. 1
- ARTICLE: PERVERSE INCENTIVES: WHY EVERYONE PREFERS HIGH DRUG PRICES--EXCEPT FOR THOSE WHO PAY THE BILLS, 57 Harv. J. on Legis. 303
- ARTICLE: A Systems Thinking Approach to Health Care Reform in the United States, 21 DePaul J. Health Care L. 1
- ARTICLE: BEYOND OBAMACARE: LESSONS FROM MASSACHUSETTSA Brief History of Health Care Reform in Massachusetts, 14 J. Health & Biomed. L. 285

Practical Guidance

Practice Notes

- Affordable Care Act Resource Kit

Articles

- Proposed Price Transparency Rules for Health Care Plans

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Jacob assists clients in drafting employee benefit plan documents and amendments. He represents clients in matters before the Internal Revenue Service (IRS), US Department of Labor (DOL) and Pension Benefit Guaranty Corporation with respect to plan qualification issues. He also counsels privately and publicly held corporations and tax-exempt entities on a variety of benefits and Employee Retirement Income Security Act (ERISA) issues, including ERISA fiduciary issues, compliance with the Affordable Care Act and the Health Insurance Portability and Accountability Act (HIPAA), ERISA implications in corporate transactions, ERISA administrative claims and appeals, and executive compensation matters.

While in law school, Jacob was editor in chief of the *Penn State Law Review*. In addition, Jacob served as a legal intern for the Honorable Judge Renee Cohn Jubelirer of the Commonwealth Court of Pennsylvania. Jacob is the Chairperson of the Young Professionals Board of Equip for Equality. Internally, Jacob serves on the Firm's Pro Bono and Community Service Committee.

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Judith has extensive experience advising clients on health care law reform; wellness programs; Medicare secondary payor rules; fiduciary compliance; disability leaves and FMLA; the Health Insurance Portability and Accountability Act (HIPAA) privacy and security compliance; subrogation and claims reimbursement; state and local compliance; consumer driven health care initiatives, including HRAs and HSAs; continuation coverage (COBRA); fringe benefit programs; executive physical programs; cafeteria plans and domestic partnership coverage.

Judith represents clients before state and federal departments of Health and Human Services (HHS), including the Office of Civil Rights, with regard to HIPAA privacy/security violations; the Center for Medicare and Medicaid Services (CMS), with regard to Medicare retiree subsidies; and the Department of Labor (DOL), with regard to health and welfare plan audits. Judith has extensive experience with payroll audits and the Internal Revenue Service (IRS).

She is also a member of our legal cannabis industry group. Our Cannabis Industry group is a multidisciplinary team of lawyers providing clients with regulatory, litigation, intellectual property, trade and tax services with respect to their investments and participation in the cannabis industry, all subject to the Firm's obligations under federal and state laws and bar licensure rules.

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Prior to joining McDermott, Sarah worked for the National Economic Council at the White House, where she implemented the Affordable Care Act and developed the DOL fiduciary rule with leaders from the Executive Office of the President, the Department of Labor, the Department of Health and Human Services and the Department of the Treasury. Sarah previously worked with in-house attorneys and federal and state government relations professionals in the Leadership Development Program of a Fortune 500 global insurance and financial services corporation.

During law school, Sarah served as a contributing editor for and was published in the *Iowa Law Review*.