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Final Transparency in Coverage Rules Introduce New Disclosure Requirements for Group Health Plans

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In November 2020, the Department of Health and Human Services, Department of Labor, and Department of Treasury (the Departments) jointly issued final transparency in coverage rules for group health plans. These rules require new public and individual disclosures regarding cost-sharing, in-network provider negotiated rates, historical out-of-network allowed amounts, and drug pricing information.

The new disclosure requirements are phased in over a three year period, with the first disclosures effective for plan years beginning on January 1, 2022. Plan sponsors should take steps this year to ensure that they are taking adequate steps to be prepared to comply with the rules. The following briefly discusses the new disclosure requirements:

January 1, 2022 (Public Disclosures)

For plan years beginning on or after January 1, 2022, the final rules require public disclosure by plans of pricing information in three categories:

- The payment rates negotiated between plans and providers for all covered items and services;
- The unique amounts a plan allowed, as well as associated billed charges, for covered items or services furnished by out-of-network providers during a specified time period; and
- Pricing information for prescription drugs.

Disclosures are required to be made in "machine-readable files" (i.e., a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention.) Files will need to be made available on a website, with the purpose of "allowing for public access to health coverage information that can be used to understand health care pricing and potentially dampen the rise in health care spending."

January 1, 2023 (Limited Individual Disclosures)

In addition to the public disclosures, for plan years beginning on or after January 1, 2023, plans will be required to disclose to participants, beneficiaries, and enrollees certain cost-sharing information for 500 items and services identified by the Departments. A table of the 500 items and services is included in the final

rules, and the Departments will publish a copy of this list on a publicly available website. The cost-sharing information must be made available through a self-service tool on an internet website. Additionally, the information must be made available in paper form upon request.

The required cost-sharing information includes:

- An estimate of the cost-sharing liability for the furnishing of a covered item or service by a particular provider or providers.
- The individual's accumulated amounts (i.e., the amount of financial responsibility that the individual has incurred at the time the request for cost-sharing information is made, with respect to a deductible and/ or an out-of-pocket limits).
- The in-network rate for a covered item or service. The in-network rate is comprised of as applicable, the network rate or underlying fee schedule rate, reflected as a dollar amount.
- The out-of-network allowed amount, or any other rate that provides a more accurate estimate of an amount the plan will pay for the requested covered item or service, reflected as a dollar amount.
- If an item or service is subject to a bundled payment arrangement, a list of the items and services included in the bundled payment arrangement for which cost-sharing information is being disclosed.
- If applicable, notification that coverage of a specific item or service is subject to a prerequisite.
- A notice that includes the following information in plain language:
    - If balance billing is permitted under applicable state law, a statement that out-of-network providers may bill participants, beneficiaries, or enrollees for the difference between a provider's billed charges and the sum of the amount collected from the group health plan or health insurance issuer and from the participant, beneficiary, or enrollee in the form of a copayment or coinsurance amount, and that the provided costs-sharing information does not account for these potential additional amounts;
    - A statement that the actual charges for an individual's covered item or service may be different from a provided estimate of cost-sharing liability, depending on the actual items or services the individual receives at the point of care;
    - A statement that the estimate of cost-sharing liability for a covered item or service is not a guarantee that benefits will be provided for that item or service;
    - A statement disclosing whether the plan counts copayment assistance and other third-party payments in the calculation of an individual's deductible and out-of-pocket maximum;
    - For items and services that are recommended preventive services, a statement that an in-network item or service may not be subject to cost-sharing if it is billed as a preventive service if the group health plan or health insurance issuer cannot determine whether the request is for a preventive or non-preventive item or service;
    - Any additional information, including other disclaimers, that the group health plan or health insurance issuer determines is appropriate (and does not conflict with the required information).

January 1, 2024 (Expanded Individual Disclosures)

For plan years beginning on or after January 1, 2024, the cost-sharing information described must be made available for all items and services (not just the 500 listed in the final rules).

If you have questions or would like additional information, please contact a member of our Employee Benefits and Executive Compensation Practice Group.

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