Federal Agencies Finalize Price Transparency Disclosure Rules under Affordable Care Act

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Recently, the Departments of Health and Human Services, Treasury, and Labor (the "Federal Agencies") jointly issued a final regulation requiring that group health plans and health insurance issuers disclose certain pricing and cost-sharing information. The new regulation will ultimately require group health plan sponsors to revisit their contractual arrangements with their third party administrators and health insurance issuers to ensure compliance.

Specifically, the Federal Agencies divide the disclosures into two major types: (1) disclosing price information for covered items/services via mandatory public website; and (2) disclosing specific cost-sharing information to individual participants and beneficiaries. The new disclosures apply to non-grandfathered group health plans and health insurance issuers, but do not apply to retiree-only group health plans, excepted benefits (such as limited-scope dental or vision coverage), or account-based group health plans (such as a health flexible spending account or a health reimbursement arrangement). Moreover, as explained below, while group health plans could be ultimately responsible for compliance with the new requirements, third party administrators and health insurance issuers will likely bear the burden for creation and distribution of the disclosures.

Please note the regulation (including preamble) is well over 500 pages in length, and as a result, this e-mail news alert merely summarizes the essential elements of the rule.

Mandatory Public Price Information

Effective for plan years beginning on and after January 1, 2022, covered group health plans and health insurance issuers must make available on a publicly-available internet website three machine-readable files of price information (the Federal Agencies define a "machine-readable file" to be "digital

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representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost" such as JSON, XML, or CSV). The three online files must consist of:

- An in-network rate file for all covered items and services (including billing codes and applicable rates such as negotiated rates, underlying fee schedule rates, or derived amounts);
- An out-of-network allowed amount file (i.e., the maximum amount a group health plan or health insurance issuer will pay for a covered item or service furnished by an out-of-network provider); and
- A prescription drug file (including negotiated rates and historical net prices).

The files must be publicly available, updated monthly, and in a form and manner as specified in guidance by the Federal Agencies in compliance with Federal and state privacy and security laws. The files must be accessible to any person free of charge and without conditions (e.g., no user account, password, or other credentials may be necessary to access the information).

Cost-Sharing Disclosures

The Federal Agencies also direct covered group health plans and health insurers to provide certain cost-sharing information to enrolled participants and enrolled beneficiaries (including duly authorized representatives), starting with plan years beginning on January 1, 2023. Specifically, covered group health plans and health insurance issuers must provide certain cost-sharing information, including:

- Estimated cost-sharing liability for requested covered items or services
- Accumulated amounts (e.g., amounts that have counted towards a deductible or out-of-pocket limit)
- In-network rates, including the negotiated rate and the underlying fee schedule rate
- Out-of-network allowed amounts
- A list of the items and services included in a bundled payment arrangement
- Whether a specific item or service is subject to a prerequisite
- Mandatory notice statements/disclaimers

Covered group health plans and health insurance issuers may disclose the cost-sharing information by internet-based self-service tool or by paper. In the event of internet disclosure, covered group health plans and health insurance issuers must ensure the tool provides responses in real-time, while allowing users to search for cost-sharing information based on network, geography, and multiplicity in compliance with Federal and state privacy and security laws. Covered group health plans and health insurance issuers must issue paper disclosures no later than 2 business days after a request, and may do so via alternative means (by phone or email) if so asked.

While the disclosure rule is effective for plan years beginning on and after January 1, 2023, covered group health plans and health insurance issuers may phase-into compliance with the rule. Specifically, in 2023, covered group health plans and health insurers need only disclose the 500 items and services as listed by the Federal Agencies. Starting in 2024, covered group health plans must disclose all covered items and services.

Disclosure Agreements and Good Faith Relief

Covered self-funded group health plans may enter into a written agreement directing a third party to disclose the required information. However, the covered self-funded group health plan will ultimately be liable for any failure by the third party to deliver the disclosures (not the third party). Please note that, with respect to an insured group health plan, when the plan sponsor and health insurance issuer enter into an agreement where the insurer will disclose the required information, the issuer will ultimately be liable for any failure to disclose (not the group health plan).

The regulation does provide relief to covered group health plans and health insurance issuers who err in meeting the disclosure requirements or because the website is temporarily inaccessible, so long as the plan or issuer acted in good faith and with reasonable diligence and corrects as soon as practicable. Furthermore, to the extent the covered group health plan or health insurance issuer must obtain information from another entity to satisfy its disclosure obligations, the covered group health plan or health insurance issuer will not fail to comply with the disclosure rules if it acted in good faith on the information (unless the covered group health plan or health insurance issuer knows or has reason to know the information is not correct).

Next Steps

Administrators of covered group health plans should contact their third party administrators and health insurance issuers to create a timeline for implementation of the disclosure rules in order to ensure compliance. Administrators of group health plans should also revisit their contracts with third party administrators and health insurance issuers to make revisions to address these new obligations and associated issues.

If you have questions regarding the new disclosure requirements or other employee benefits matters, please contact your regular Butzel Long attorney, a member of the Butzel Long Employee Benefits Practice Group, or the author of this e-mail news alert.

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