Final Rules on Coverage Transparency

7-Minute Read

On October 29, 2020, the Internal Revenue Service (IRS), Department of Labor (DOL), and the Department of Health and Human Services (HHS) (collectively, Departments), released final rules on coverage transparency, in order to provide health coverage recipients with an estimate of their potential cost-sharing liability for health related services prior to the receipt of care. The final rules require group health plans and insurance issuers in the individual and group markets to disclose cost-sharing information and negotiated rates in electronic or paper form. It is important that plan sponsors and issuers agree, in writing, on which party will be responsible for satisfying the disclosure obligation. The final rules also allow issuers to reward plan enrollees with "shared savings payments," without running afoul of medical loss ratio (MLR) requirements. Issuers are permitted to provide employees who use lower-priced providers with a percentage of the savings relative to a benchmark. Please see our Advisor on the final rules for more detail.

HHS has released a fact sheet and a press release regarding the final rules.

Applicability

The following types of plans and coverage aren't subject to the final rules: grandfathered health plans; excepted benefits; health care sharing ministries; short-term, limited-duration insurance; or other account-based health plans (FSAs, HSAs, and HRAs, including ICHRAs and QSEHRAs) that simply make certain dollar amounts available.

Effective Dates

- Public Disclosure of Negotiated Rates and Historical Allowed Amounts: January 1, 2022
- Disclosure of Cost Information: January 1, 2023, through January 1, 2024 (three-year phase-in)
- Medical Loss Ratio Calculation: 2020 MLR Reporting Year

Highlights

Disclosure Obligation

A plan or issuer must disclose information regarding a covered item or service upon request, including: 1) estimated cost-sharing liability; 2) the amount of financial responsibility that a participant, beneficiary, or enrollee has incurred at the time the request for cost-sharing information is made, with respect to a deductible and/or an out-of-pocket limit; 3) in-network rates; 4) out of network rates; 5) items and services content list; and 6) notice informing the individual that a specific covered item or service for which the individual requests cost-sharing information may be subject to a prerequisite for coverage, with disclaimers regarding out-of-network charges, actual charges, and estimated cost sharing liability.

Electronic Disclosure

Electronic disclosure must be made via an internet based self-service tool which allows the user to search for real-time cost-sharing information provided by a specific in-network provider, or by all in-network providers. The tool must also allow users to search for the out-of-network allowed amounts. The tool must allow the user to refine and reorder search results based on geographic proximity of in-network providers. Plans and issuers are encouraged to rely upon federal plain language guidelines and ERISA disclosure requirements for presentation, and general industry standards for guidance on developing internet-based self-service tools. The tool must be accessible via website.

Paper Disclosure

Upon request by the participant, beneficiary, or enrollee, the cost-sharing information described above must be disclosed in paper form. Similar to the requirements for the internet-based self-service tool, the plan or issuer must allow an individual to request cost-sharing information for a discrete covered item or service by billing code or descriptive term. The information must be mailed to the requesting participant, beneficiary, or enrollee no later than two business days after the request is received. A plan or issuer may limit any results for a paper request to 20 providers per request.

Public Disclosure

Group health plans and health insurance issuers must disclose to the public, through three machine-readable files: 1) the negotiated rates for in-network providers for all covered items and services; 2) unique amounts a plan or issuer allowed for all covered items or services, including prescription drugs, furnished by out-of-network providers during a specified time period; and 3) prescription drug pricing information for in-network providers. The files must be available on a website and must be accessible free of charge, without requiring the user to establish an account, password, or other credentials, and without having to submit any personal identifying information such as a name or email address.

Good Faith Safe Harbor

A plan or issuer will not fail to comply with the final rules, if acting in good faith and with reasonable diligence and errors and omissions are corrected as soon as possible. To the extent such error or omission is due to good faith reliance on information from another entity, the final rules include a

special applicability provision that holds the plan or issuer harmless, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate.

Shared Savings and the MLR Rule

Shared savings may be factored into an issuer's MLR calculation beginning with the 2020 MLR reporting year. If a plan is designed to incentivize consumers to shop for services from lower cost, higher-value providers and the design results in savings, issuers can take credit for the "shared savings" payments made to participants in the numerator of the MLR calculation. Issuers are not required to pay MLR rebates based on a plan design that provides a benefit to consumers that is not currently captured in any existing MLR revenue or expense category.

Next Steps

- **Fully Insured Plans –** Due to the quickly approaching effective date for the coverage transparency provisions, employers with fully insured plans are encouraged to promptly coordinate with their group health plan issuers to determine which entity will be handling the disclosure requirements noted above. Employers/plan sponsors should consider entering into a written agreement with their fully insured plan issuers that sets forth each entities' obligations. If a group health plan enters into a written agreement under which the issuer agrees to provide the required information described above, and the issuer fails to meet the requirements, the issuer, not the plan, is in violation of the final rules. Plans and issuers may fulfill pricing disclosure requirements for prescription drugs through a third-party tool, such as a pharmacy benefit management (PBM) tool, however, if the tool fails to provide information in compliance with the final rules, the plan or issuer may be held responsible for the violation.

- **Self-Insured Plans –** Self-insured and level-funded plans should also consider entering into written agreements with third-party administrators (TPAs) in order to comply with the requirements noted above. However, unlike fully insured plans, self-funded and level-funded plans will still be considered to violate the final rules even if the written agreement provides that the TPA has responsibility for complying with the final rules and a violation occurs. Note that these plans can still insert indemnification provisions into the written agreements.

Penalty

A group health plan could be subject to an excise tax of $100 per affected individual per day for violations of the final rules.

Employers should stay apprised of future guidance as the final rules note that the Departments will be releasing future guidance regarding required data elements for the machine-readable files.

11/2/2020