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Proposed Rules Require Health Plans and Insurers to Provide Cost Transparency

On November 15, 2019, in response to President Trump's executive order on Improving Price and Quality Transparency, the Departments of Labor, Health and Human Services, and Treasury (collectively, the "Departments") issued a proposed rule regarding transparency in health coverage costs. The proposed rule requires non-grandfathered group health plans and insurers to:

- Give participants, dependents and enrollees real-time, personalized online access to cost-sharing information, including an estimate of their cost-sharing liability for any covered item or service from any particular provider or providers (in paper form upon request); and

- Disclose on a public website, through two machine-readable files, the negotiated rates for in-network providers and the allowed amounts paid for out-of-network providers.

The proposed rule does not apply to grandfathered plans or excepted benefits under the Affordable Care Act, health reimbursement arrangements or other account-based group health plans.

Personalized Cost-Sharing Estimates

The proposed rule requires group health plans and insurers to offer a tool on a website into which users can input service and provider information and see real-time cost estimate results. The tool would provide information similar to the information generally found in an explanation of benefits ("EOB"). Among other items, the results must describe the following if relevant to the person's cost-sharing:

- An individualized estimate of the person's cost-sharing liability;

- The individual's accumulated amounts (e.*g.*, deductible, out-of-pocket limit, and any cumulative treatment limit), not including unprocessed claims;

- The negotiated rate, in U.S. dollars, for the requested item or service from an in-network provider, or the allowed amount for the item or service if the estimate is for an out-of-network provider;

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- Notice of any prerequisites to coverage (*e.g.*, prior authorization, concurrent review, step-therapy or fail-first protocols); and
- Various disclosures and caveats regarding cost and benefit estimates.

The proposed rule also specifies requirements for the website tool's user interface. Plan sponsors and insurers must develop the tool so as to allow users to perform the following functions:

- Search for cost-sharing information by either a billing code or a descriptive term;
- Search for a specific in-network provider, or all in-network providers (including each tier for a multi-tier network);
- Search for the out-of-network allowed amount; and
- Sort and filter results by geographic proximity and the amount of estimated cost-sharing liability.

If the participant, dependent or enrollee requests the information in paper form, the plan administrator or insurer must deliver the information, free of charge, within two business days after receipt of the request.

Disclosure of Negotiated Rates and Allowed Amounts

The proposed rule also requires group health plans and insurers to publically post on a website two machine-readable files that include information on covered costs. One file would provide information on negotiated rates with in-network providers (the "Negotiated Rate File"), while the other would provide information on allowed amounts for covered items or services from out-of-network providers (the "Allowed Amount File"). Plans and insurers would need to update these files monthly.

Among other items, the Negotiated Rate File would provide the network's negotiated rates, in U.S. dollars, for each covered item or service. The Allowed Amount File would provide each unique allowed amount, in U.S. dollars, for covered items or services furnished by out-of-network providers during the 90-day period that begins 180 days before the file is published.

How Will Plans Comply?

An insured plan could satisfy the proposed rule's file requirements if the insurer

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contracts to provide the information. A plan or insurer may also contract with a health care claims clearinghouse, third-party administrator or other HIPAA-compliant entity to disclose the data on its behalf. However, the plan or insurer would retain liability if the third party fails to provide complete or timely information.

Penalties and Good Faith Efforts

The proposed rule does not specifically provide for a penalty for noncompliance. However, because the proposed rule is proposed under chapter 100 of the Internal Revenue Code (the "Code"), the Code section 4980D penalty would apply if a plan or insurer fails to comply. That penalty generally is $100 per day for each individual to whom such failure relates.

The proposed rule does provide for a good-faith safe harbor. If despite acting in good faith and with reasonable diligence, a plan or insurer makes an error or omission in a required disclosure, or its website becomes temporarily inaccessible, it would not be deemed noncompliant, provided it makes the information available as soon as practicable. Additionally, if a plan or insurer relies in good faith on information obtained from another entity which subsequently is discovered to be incomplete or inaccurate, the plan or insurer would not be deemed noncompliant unless it knew, or reasonably should have known, the information was, in fact, incomplete or inaccurate.

Effective Date and Potential Outcomes

If finalized, the proposed rule would become effective for plan years beginning on or after one year after the final rule's effective date. For calendar-year-based coverage, the earliest the rule could become effective is January 1, 2022.

Employers that sponsor self-funded plans might find these requirements difficult to meet with their current claim payment arrangements and the confidentiality provisions in their network contracts. Such employers likely would need to pay third parties, like their claims administrators, to provide the services required by the proposed rule. Costs may also increase, at least initially, for employers with insured plans, as the proposed rule states an insured plan would comply and have no liability only if the insurer is contractually required to provide the information.

The Departments requested comments about nearly every aspect of the proposed rule, including alternatives to the proposed requirements. Comments are due by January 14, 2020. Numerous comments are expected and significant

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changes may follow in the final rule. At that time, group health plan sponsors can better assess how onerous the rule will be for cost-effective plan administration.

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