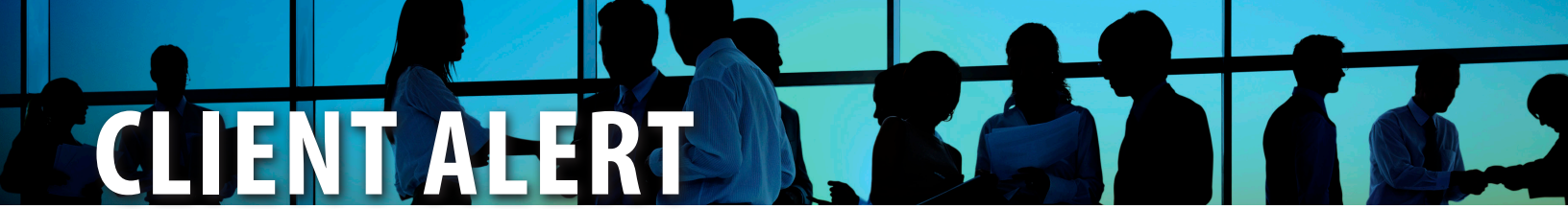


GROUP HEALTH PLAN TRANSPARENCY DISCLOSURE RULES FINALIZED: WHAT PLAN SPONSORS SHOULD KNOW

By Cynthia A. Moore

The Department of Labor (DOL), the Internal Revenue Service (IRS) and the Department of Health and Human Services (HHS) (collectively, Agencies) issued final regulations in November 2020 requiring non-grandfathered group health plans and health insurance issuers to disclose cost-sharing information to participants and make pricing information for medical items and service publicly available. The final regulations implement Section 2715A of the Public Health Service Act, one of the market reforms added as part of the Affordable Care Act (ACA), which is incorporated by reference into ERISA and the Internal Revenue Code (Code).

Section 2715A requires non-grandfathered group health plans to comply with Section 1311(e)(3) of the ACA, which requires qualified health plans on a Health Insurance Exchange (Exchange) to make certain transparency disclosures regarding plan operation. Among those transparency disclosures are "information on cost-sharing and payments with respect to any out-of-network coverage" and "other information as determined appropriate by the Secretary." The DOL is directed to update and "harmonize" ERISA disclosures to participants made by group health plans pursuant to the transparency rules.

Which Plans Are Subject to the Transparency Disclosure Rules?

All non-grandfathered group health plans, both self-insured and fully insured, must comply with the transparency disclosure rules, other than:

- Health reimbursement arrangements or other account-based plans;
- Short-term limited-duration insurance; and
- Excepted benefits (such as standalone dental and vision plans).

What Information Must be Disclosed to Participants?

Upon request of a participant, a plan must make available, in real-time via an Internet-based self-service tool, the participant's cost-sharing liability for a covered item or service furnished by a designated provider. Cost-sharing liability includes deductibles, coinsurance, and copayments. The estimate will be based on the negotiated rate for an in-network provider or the allowed amount for an out-of-network provider. The disclosure must include any prerequisite that must be satisfied before the plan will provide coverage, such as prior authorization or step therapy. A notice must also be included with certain cautions, including that the disclosure is an estimate and may vary based on the actual items and services provided to the participant and that the estimate is not a guarantee of coverage. The Agencies have published a model notice, which can be accessed at: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-draft-model-disclosure.pdf

The self-service tool must also permit participants to search for cost-sharing liability by searching a CPT code or a specific term (such as "rapid flu test"). This search can be directed to in-network or out-of-network providers; once results are obtained, the participant must be able to sort the results by geographical proximity of in-network providers or by the amount of the estimated cost-sharing liability.

Participants can alternatively make a paper request for this information; the plan must mail the cost-sharing information to the participant within two business days after receiving the request.

Some of the reasons given by the Agencies for adopting this rule are to give consumers information to make more informed health care decisions and to reduce the potential for surprise billing. The disclosures do not, however, include any quality information, so participants should keep this in mind when making a health care purchasing decision.

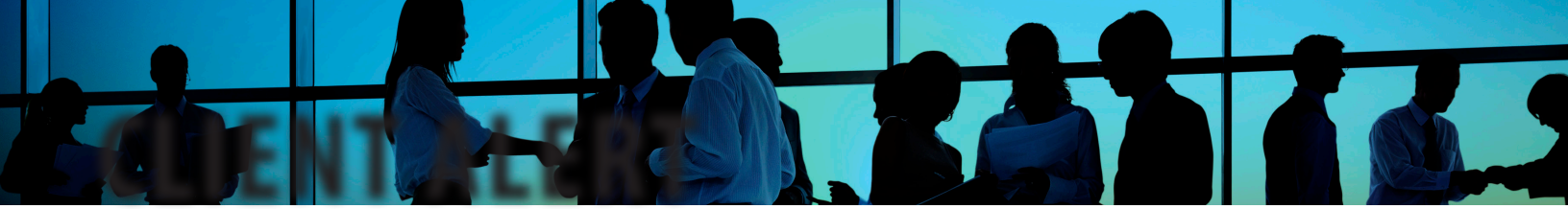
What Transparency Information Must be Publicly Disclosed?

Each non-grandfathered group health plan must make three machine-readable files publicly available, listing:

- In-network provider rates for all covered items and services;
- Out-of-network allowed amounts and billed charges for all items and services; and
- Negotiated rates and historical net prices for covered prescription drugs.

The machine-readable files must be updated monthly. They must be publicly available and accessible to any person, free of charge. Plans and health insurance issuers cannot impose conditions on accessing the data, such as establishment of an account or password, or submission of personally identifiable information.

The Agencies believe that these disclosures will empower consumers, increase competition and potentially help to contain health care costs. Plan sponsors could use the data to develop plan designs to encourage participants to use lower-cost providers. Insurers objected to the public disclosures on multiple grounds, including that the negotiated rates are proprietary and would involve a disclosure of their confidential trade secrets in violation of various statutes and contracts with providers; and could cause health care costs to increase. The Agencies were not persuaded by these objections.



One can only imagine that the machine-readable files will be massive and difficult to navigate. The Agencies anticipate that third parties will access the data and create user-friendly apps or web-based tools that consumers can use to compare prices for a medical service or item at different providers.

When Do the Transparency Disclosure Rules Become Effective?

The participant-level transparency disclosure rules will become effective for plan years beginning on or after January 1, 2023, for 500 common items and services listed in the preamble to the final regulations. Participant-level disclosures must be available for all covered items and services for plan years beginning on and after January 1, 2024.

The machine-readable files that must be made publicly available apply to plan years beginning on or after January 1, 2022.

How Does an Insured Group Health Plan Comply with the Transparency Disclosure Rules?

The insurer for a group health plan will make the transparency information available on behalf of an insured plan if required by a written agreement. In this event, the insurer, and not the plan sponsor, would be responsible for compliance with the transparency disclosures.

How Does a Self-Funded Group Health Plan Comply with the Transparency Disclosure Rules?

A self-insured plan will likely contract with its third-party administrator ("TPA") or pharmacy benefit manager to make the transparency disclosures. However, if the TPA fails to comply with the disclosure rules, the plan sponsor is responsible. Plan sponsors will need to review their TPA agreements carefully, confirm that the TPA will comply with the transparency disclosures, and consider appropriate indemnification or other protections.

What Penalties Could Apply if a Group Health Plan Failed to Comply with the Transparency Disclosure Rules?

If the plan is insured and the insurer agreed to provide the disclosures, the plan should not be subject to any penalties – the insurer would be responsible for compliance.

If the plan is self-insured and either the plan or its TPA failed to comply with the disclosure rules, the plan could be subject to an enforcement action under ERISA and to the $100 per day excise tax penalty under Section 4980D of the Code (which applies to any failure to comply with the ACA's market reforms.)

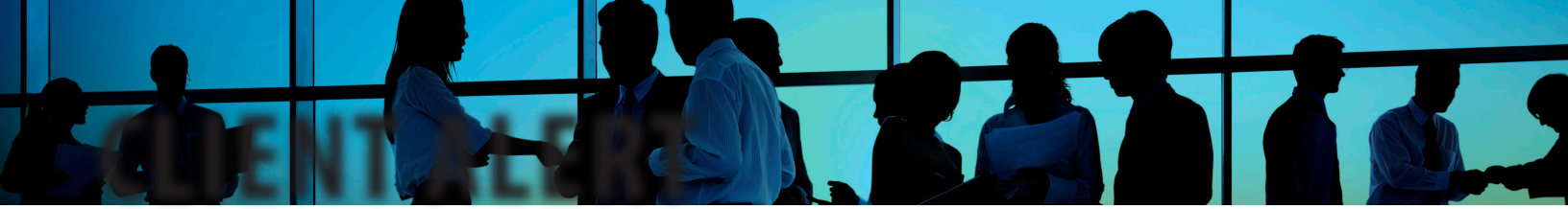
How are the Transparency Disclosures "Harmonized" with the ERISA Disclosure Rules?

Each welfare benefit plan subject to ERISA must provide participants with a summary plan description ("SPD") that includes information about the plan and its operation, including a description of benefits, exclusions, and limitations, claim and appeal procedures, and administrative information. An SPD for a group health plan must describe any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible. The information that is required to be disclosed under the new transparency rules is different in that it is a real-time estimate of the actual dollar amount that a participant will be required to pay for a particular medical item or service received from a particular provider. This type of information would be impossible to be disclosed in an SPD. The transparency disclosure rules do not contain any language "harmonizing" them with the SPD disclosure rules, perhaps because the purpose of the transparency disclosures is somewhat different. We foresee that the SPD disclosure rules could be modified to require an SPD to disclose a participant's ability to request the participant-level disclosures and to access the machine-level files, and provide appropriate directions on how to access those tools and features.

Next Steps

As January 1, 2022 approaches, each plan sponsor should touch base with its insurer or TPA to confirm that the insurer/TPA is preparing to make the machine-readable files publicly available and is working to make the participant-level disclosures available beginning in 2023. The plan sponsor should also make sure that its contract with the insurer or TPA obligates the insurer/TPA to make the transparency disclosures. As mentioned previously, a self-funded plan is responsible if the TPA fails to comply, so the plan sponsor should consider whether other protections are appropriate, such as a specific indemnification from the TPA.

If you have any questions about the transparency disclosure rules, please contact Cynthia A. Moore or any other member of Dickinson Wright's Employee Benefits and Executive Compensation Group.



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