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Group Health Plan Sponsors are Getting Serious About Pricing Transparency – Are You Keeping Up?

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In early July, the Department of Health and Human Services (HHS), the Department of Labor (Labor), and the Department of the Treasury (Treasury) (collectively, the Departments), along with the Office of Personnel Management (OPM) released an interim final rule related to the No Surprises Act, legislation designed to protect patients from unexpected medical bills.

The Departments' interim final rule arrives in the broader context of a number of new health cost transparency obligations imposed upon plan sponsors (the employers or organizations that offer group health plans to employees) beginning in early 2022. While third parties can implement many of the pricing transparency measures, plan fiduciaries must ultimately ensure compliance. As compliance deadlines for new pricing transparency requirements for group health plans draw near, plan sponsors will need to use the second half of 2021 to prepare.

First, the Departments issued the Transparency in Coverage Rule in late 2020. Under the rule, group health plans (and health insurance issuers in the individual and group markets) must (1) upon request, disclose cost-sharing information to

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participants, beneficiaries and enrollees *and* (2) disclose in-network provider negotiated rates, historical out-of-network allowed amounts, and prescription drug pricing information to the public via machine-readable files posted to a website. The Transparency in Coverage Rule takes effect in January 2022, but much of the heavy lifting will occur during this year's current service agreement and vendor contract negotiation cycle.

Separately, plan sponsors must also contend with the employee benefit health and welfare plan provisions of the Consolidated Appropriations Act of 2021 (CAA). The CAA, which includes the No Surprises Act, includes a myriad of transparency and disclosure requirements that take effect in 2021 and 2022. Plan sponsors will need to work closely with service providers and issuers to ensure that group health plans are well-positioned to comply. Below we provide a high-level summary of the new rules.

Transparency in Coverage Rule

The regulations issued by the Departments create a federal standard designed to provide consumers with health pricing information necessary to make informed decisions. The Transparency in Coverage Rule is designed to complement the hospital pricing transparency rule that took effect earlier this year, although many hospitals appear to be deficient in complying with it.

- *Machine Readable Public Pricing Disclosures*. Beginning January 1, 2022, most non-grandfathered group health plans and health insurance issuers offering non-grandfathered health insurance coverage must disclose pricing information to the public through three machine-readable files. One file will disclose payment rates negotiated between plans or issuers and providers for all covered items and services. The second file will disclose the unique amounts a plan or issuer allowed, as well as associated billed

charges, for covered items or services furnished by out-of-network providers during a specified time period. A third file must include prescription drug pricing information.

- *Cost-Sharing Information Self-Service Tool*. Most non-grandfathered group health plans and health insurance issuers offering non-grandfathered health insurance coverage must disclose, upon request, cost estimates (in the form of seven content-specific elements) for covered items and services. Disclosures must be made through a self-service tool made available by the plan or issuer on an internet website (and in paper form upon request). Plans and issuers are required to provide estimates for an initial list of 500 items and services beginning January 1, 2023; however, estimates for *all* items and services described in the Rule must be available by January 1, 2024.

Pricing Transparency in the CAA

The CAA, one of the longest bills ever passed by Congress, contains a number of pricing transparency provisions that apply to providers and group health plans. Many provisions are effective in 2022 while others took effect earlier this year.

- *No "Gag" Clauses.* Effective January 1, 2021, group health plans and health insurers may not enter into agreements with health providers (or a network of providers), third-party administrators or other service providers that would restrict those parties from disclosing specific price or quality information.
- *Mental Health Parity Disclosures*. Effective February 10, 2021, group health plans must perform and document comparative analyses of compliance with the Mental Health Parity and Addiction Equity Act.
- *New 408(b)(2) Disclosures.* Covered service providers must disclose their direct and indirect compensation above $1,000 received during the term of a contract or arrangement to a

responsible plan fiduciary of a covered health plan. Annual disclosure requirements are effective December 27, 2021.

- *Mandatory Drug Price Reporting*. Group health plans must provide the Departments with certain information regarding costs associated with the plan's prescription drug benefit, effective December 27, 2021. Subsequent annual disclosures will be due by June 1 of each year.
- *No Surprises Act*. Major provisions in the No Surprises Act language under the CAA include a ban on: (1) surprise billing for emergency services, (2) high out-of-network cost-sharing for emergency and non-emergency services, (3) out-of-network charges for ancillary care at an in-network facility in all circumstances, and (4) other out-of-network charges without advance notice. The No Surprises Act also requires plans to provide patients with advanced explanations of benefits before scheduled care (upon request), establishes plan ID card criteria, establishes plan continuity of care requirements for certain patients, and creates a negotiation and arbitration framework for settling pricing disputes between insurers and providers. Under the No Surprises Act, plans will be required to have a verifiable provider directory. Plans must also maintain a pricing comparison tool (available online and on the phone) to allow patients to compare expected out-of-pocket costs for items and services across multiple providers. For group health plans and health insurance issuers, the provisions will take effect for plan, policy, or contract years beginning on or after January 1, 2022.

The Departments will continue to release additional guidance to ensure that insurers, providers, and plans are prepared to comply with the new health plan transparency standards. Plan sponsors will need to review various agreements, plan documents, and draft disclosures well in advance of effective compliance deadlines. Compliance may also come at a cost –plan sponsors should be prepared for a

potential short-term increase in administrative costs associated with implementation. Finally, it is also important to keep up with new guidance as the information becomes available in the coming months. As noted above, effective dates are rapidly approaching and significant “heavy lifting” will be necessary for plan sponsors to ensure they are compliant at the appropriate time. Should you have questions about how these new rules will impact your plan, contact your Akerman attorney.
