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compliance ALERT

Agencies Issue Healthcare Transparency Rules for 2022 and Beyond

November 9, 2020

On October 30, the IRS, DOL and HHS jointly issued final regulations (the "Final Rules") that require most group health plans (including both fully-insured and self-insured plans)[1] and insurers to make certain cost and coverage-related disclosures to participants, beneficiaries, enrollees, and, in some cases, the public. The Final Rule's disclosure requirements initially go into effect on January 1, 2022, and then impose additional requirements that are effective over the next two years. These agencies also issued a Fact Sheet about the new Final Rules.

The Final Rules are designed to improve healthcare price and coverage transparency, as required by the Affordable Care Act (ACA), and in a manner consistent with President Trump's June, 2019 Executive Order on this topic.

How are the Final Rule's Requirements Different for Sponsors of Fully-insured Plans vs. Self-insured Plans? Who is Responsible for Compliance Failures?

- **Fully-insured Plans.** The Final Rules do not require plan sponsors offering fully-insured group health plans to comply with these new disclosure requirements if they have a written agreement in place with their insurer indicating that the insurer will be responsible for compliance.
- **Self-insured Plans.** By contrast, the Final Rules require that sponsors of self-insured health plans comply, but such sponsors can contract with a third party administrator (TPA), healthcare claims clearinghouse, or other HIPAA-compliant entity or vendor to provide the necessary disclosures and ensure compliance. However, sponsors of self-insured health plans remain ultimately responsible if they contract with other third parties to provide the disclosures. For example, the Final Rules clarify that plans and insurers that enter into a business associate agreement with a healthcare claims clearinghouse or other HIPAA-compliant entity to prepare the required machine-readable files for public disclosures (discussed below) are ultimately responsible for compliance failures.

How Does the Final Rule Change the Law? What are the Main Compliance Requirements of the New Final Rules?

The Final Rule is expansive, and it imposes a substantial amount of new disclosure requirements on insurance carriers and group health plans. These disclosure

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- The IRS, DOL and HHS jointly issued final regulations that require many new disclosures from insurance carriers and group health plans.
- These requirements initially go into effect on January 1, 2022, and then impose additional requirements over the next two years.
- HR and Benefits teams should begin preparing for these compliance responsibilities as soon as possible.

[1]The Final Rules do not apply to ACA-defined grandfathered plans, health reimbursement arrangements (HRAs), health FSAs, excepted benefits, or short-term limited-duration insurance (STLDI).

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requirements generally fall into two main categories: (1) participant disclosures containing cost-sharing information; and (2) public disclosures regarding negotiated rates for in-network providers and allowed amounts for out-of-network providers.

Here are the highlights of several of the Final Rule's major provisions:

- **Required Participant Disclosures**. Insurers and group health plans must make advance disclosures of the specified cost-sharing information to participants, beneficiaries, and enrollees through an internet-based self-service tool and, upon request, in paper form. Disclosures are required for an initial list of 500 items and services for plan years that begin on or after January 1, 2023, with all items and services to be disclosed for plan years that begin on or after January 1, 2024.
    - **Estimated Cost-Sharing**. The estimated amount that the individual must pay for a service or covered item under the plan's terms (including deductibles, coinsurance, and copays). Additionally, separate disclosures must be made if cost-sharing is imposed separately for each unique item and service included in a bundled payment.
    - **Accumulated Amounts**. The amount of financial responsibility that an individual has incurred when the request for cost-sharing information is made (*e.g.*, as a deductible or an out-of-pocket limit) must also be disclosed. These estimates do not include amounts available through separate account-based arrangements.
    - **Out-of-Network Allowed Amount**. The maximum amount that would be paid for a service or item furnished by an out-of-network provider which includes the out-of-network allowed amount, or any other calculation, that provides a more accurate estimate (*e.g.*, the usual, customary and reasonable (UCR) amount).
    - **Negotiated Rates**. The amount the plan/insurer or a TPA have contractually agreed to pay an in-network provider for a covered item or service, such as negotiated rates (including for prescription drugs) and underlying fee schedules that result from using a formula (*e.g.*, 150% of the Medicare rate) as a dollar amount.
    - **Items and Services List**. A list of the covered items and services must be disclosed when an item or service is subject to a bundled payment arrangement.
    - **Coverage Prerequisites**. Individuals participating in the plan must receive a notice informing them that a specific item or service may be subject to a "prerequisite," which is defined as concurrent review, prior authorization, and step-therapy or fail-first protocols. The items listed in this definition are an exhaustive list (and the term "prerequisite" does not include medical management techniques or medical necessity determinations).
    - **Disclosure Notice**. Individuals must also receive a notice with several specific disclosures, including a statement about balance billing and disclaimers about differences in actual and estimated charges. Additionally, they must receive a disclosure about whether copay assistance and other third-party payments are included in deductible and out-of-pocket maximum calculations.
- **Public Disclosures**. Insurers and group health plans must also make extensive price transparency disclosures to the public in machine-readable files updated monthly. The disclosures must show negotiated rates for covered items and services between the plan or insurer and in-network providers, as well as historical payments to, and billed charges from, out-of-network providers. (As a change from the proposed rule, a separate machine-readable file must disclose relevant prescription drug information.). These disclosures are required for plan years beginning on or after January 1, 2022.
- **MLR Rebate Reduction Available for Insurers.** HHS also issued a rule (as part of these Final Rules) that would allow insurers to take credit for shared-savings programs when they conduct medical loss ratio (MLR) calculations. As background, in general, large group insurers must spend at least 85% of premiums on healthcare expenses for fully-insured plans and policies, and their failure to do so, requires them to rebate any excess amounts back to plan sponsors and their participants as MLR rebates. Under the new Final Rules,

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insurance carriers would be permitted to receive credit in their MLR calculations for savings they share with plan participants that result from the participants obtaining care from lower-cost, higher-value providers.

How will Penalties Be Assessed? Are there any Exceptions to (or Exemptions From) the Final Rule's Disclosure Requirements?

Plans that are subject to the Final Rules will be subject to the penalties and enforcement mechanisms applicable to group health plans under ERISA and the ACA, as amended by the Public Health Service Act.

There are some exceptions to the Final Rule's disclosure requirements. Specifically, a "good faith" safe harbor functions as an enforcement exception to the Final Rule, which provides that a group health plan will not fail to comply with the rule solely because it makes an error or omission, or because a public website is temporarily inaccessible, as long as it is acting in good faith and with reasonable diligence. However, the plan must correct any errors as soon as practicable. Further, if a plan needs to obtain information from another entity to comply, a plan that acts in good faith and with reasonable diligence will not be out of compliance unless the plan knows or reasonably should have known that the information is incomplete or inaccurate.

What Should Employers and Plan Sponsors Do Next?

January 1, 2022, the effective date of the Final Rules, is right around the corner, and likely to arrive sooner than many HR and Benefits teams expect. While there are some exceptions to the Final Rule's disclosure requirements (like the "as soon as practicable" safe harbor discussed above), these are not large enough to consider delaying implementation of an appropriate compliance plan.

Additionally, it should be noted that if the relevant parts of the ACA (from which these Final Rules were authorized) are held to be unconstitutional, or are otherwise invalidated by the U.S. Supreme Court, then these Final Rules will not be enforced. That is significant because on November 10, 2020, the Supreme Court is scheduled to hear arguments on whether the ACA is constitutional in the case of ***Texas v. California***. A decision in that case is expected by June of 2021.

Finally, while there is some possibility that the Sections of the ACA from which the Final Rules were issued may be invalidated by the upcoming Supreme Court case of *Texas v. U.S.*, and while this may result in these Final Rules never being enforced, a decision is not expected until the Spring or early Summer of 2021. By then, it may be too late to make the appropriate changes for the 2022 plan year, and so, it's best to begin preparing for these compliance responsibilities as soon as possible.

If you have any questions or concerns about the Final Rule and its disclosure requirements, or need assistance with developing a compliance plan, your Corporate Synergies Account Manager is ready to assist.

If you have any additional questions, please call your Corporate Synergies Account Manager or 866.CSG.1719.

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