COMPLIANCE OVERVIEW

Health Plan Price Transparency – Compliance Reminders for Employers

Employer-sponsored group health plans must comply with a variety of relatively new reporting and disclosure requirements related to health care transparency. These requirements are intended to reduce health care costs by making meaningful price information more accessible to consumers. They broadly apply to group health plans (including fully insured plans, self-insured plans and level funded plans) and health insurance issuers.

In general, most employers rely on their issuers, third-party administrators (TPAs) and other service providers to satisfy many key transparency requirements for their health plans, including the obligations to provide detailed pricing information in machine-readable files (MRFs) and submit reports on prescription drug and health care spending (RxDC reporting). Despite this reliance, employers still have important compliance obligations under federal transparency laws.

Significantly, President Donald Trump has directed the Departments of Labor, Health and Human Services, and the Treasury (Departments) to prioritize health care price transparency during his second term. Employers should watch for new guidance from the federal government implementing additional health care transparency requirements in response to this directive.

LINKS AND RESOURCES

- Transparency in coverage final rules from November 2020
- RxDC reporting website
- Gag clause attestation website

Key Requirements

Key reporting and disclosure requirements under federal transparency laws include:

- RxDC reporting;
- Gag clause attestations;
- MRFs with detailed pricing information;
- Self-service cost comparison tool;
- Balance billing notice; and
- Advanced explanation of benefits (EOB) *(implementation delayed)*

Reporting Deadlines

Health plans and issuers are subject to the following annual transparency reporting deadlines:

- **RxDC reporting**: Due each year by June 1, covering data from the prior year; and
- **Gag clause attestations**: Due each year by Dec. 31, covering the period since the last attestation.

Transparency Requirements

Reporting Requirements		
Action Item	**Description**	**Key Compliance Steps**
File RxDC report by June 1 of each year	Health plans and issuers must annually submit detailed information on prescription drug and health care spending to the federal government. This reporting is referred to as the prescription drug data collection (or RxDC report). This is an annual reporting requirement—plans and issuers must submit these reports by June 1 of each year, covering information for the prior calendar year. The RxDC report consists of several files, including those that require specific plan-level information, such as plan year beginning and end dates and enrollment and premium data. It also includes files that require detailed information about medical and pharmacy benefits. Employers may work with multiple third parties to complete the RxDC report for their health plans. A health plan's submission is considered complete after all required files are submitted, regardless of who submits them.	• Reach out to the plan's issuer, TPA or pharmacy benefit manager (PBM) (as applicable) well in advance of the deadline each year to confirm whether they will submit RxDC files for the plan; • Respond promptly to any information requests from the third party (i.e., issuer, TPA or PBM) submitting the RxDC files; • Review the plan's agreement with the third party to ensure it addresses this reporting responsibility; and • Monitor the third party's compliance with this reporting requirement for self-insured plans.
Submit gag clause attestation by Dec. 31 of each year	Health plans and issuers are prohibited from entering into contracts with health care providers, TPAs or other service providers offering access to a network of providers that contain "gag clauses" (i.e., clauses restricting the plan or issuer from providing, accessing or sharing certain information about provider price and quality and de-identified claims). Health plans and issuers must annually submit an attestation of compliance with the gag clause prohibition to the federal government. However, a fully insured health plan is not required to submit an attestation if the plan's issuer submits an attestation on behalf of the	• Review contracts with service providers (e.g., TPAs and PBMs) offering access to a provider network to confirm they do not include prohibited gag clauses; • Reach out to the plan's issuer, TPA, PBM or other service provider (as applicable) well in advance of the deadline each year to confirm whether they will submit the attestation for the plan; • Review self-insured plans' agreements with the TPA, PBM or other service provider to ensure they prohibit gag clauses in downstream agreements (i.e., separate agreements the service provider

Reporting Requirements		
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	plan. The attestation is due on Dec. 31 each year, covering the period since the last attestation.	has with other entities that provide or administer the plan's network) and address this reporting responsibility; and • Monitor the service provider's compliance with this reporting requirement for self-insured plans. Note that some service providers have been unwilling to submit gag clause attestations for their self-insured groups. Employers that submit their own attestations should review the latest instructions and user manual for submitting attestations.

Disclosure Requirements		
Action Item	**Description**	**Key Compliance Steps**
Post MRFs and make monthly updates	Health plans and issuers must disclose detailed pricing information in three MRFs on a public website. Specifically, the following MRFs are required: 1. In-network provider negotiated rates for covered items and services (In-network Rate File); 2. Historical payments to and billed charges from out-of-network providers (Allowed Amount File); and *3.* In-network negotiated rates and historical net prices for covered prescription drugs (Prescription Drug File). *This file's implementation has been delayed.* The files must be publicly available and accessible free of charge without any	• Confirm the plan's issuer (or other third party for self-insured plans, such as a TPA) has posted the In-network Rate and Allowed Amount Files and is making regular monthly updates; • Review the written agreement with the issuer (or other third party) to ensure it addresses the issuer's (or other third party's) responsibility for posting and updating MRFs; • Monitor the third party's compliance with this disclosure requirement for self-insured health plans; and • Watch for new guidance regarding transparency improvements for MRFs, including updated technical guidance and implementation of the Prescription Drug File.

Disclosure Requirements		
Action Item	**Description**	**Key Compliance Steps**
	restrictions. They also must be updated monthly.	
Provide a self-service price comparison tool	Health plans and issuers must make an internet-based price comparison tool available to participants, beneficiaries and enrollees. This tool provides consumers with real-time estimates of their cost-sharing liability from different providers for covered items and services, including prescription drugs, so they can shop and compare prices before receiving care. Health plans and issuers must provide this information in paper form upon request.	• Confirm the plan's issuer (or other third party for self-insured plans, such as a TPA) has provided the price comparison tool; • Review the written agreement with the issuer (or other third party) to ensure it addresses the issuer's (or other third party's) responsibility for providing this tool; and • Monitor the third party's compliance with this requirement for self-insured health plans.
Post balance billing notice	Health plans and issuers must provide protections against balance billing and out-of-network cost sharing with respect to emergency services, air ambulance services furnished by nonparticipating providers and nonemergency services furnished by nonparticipating providers at participating facilities. Heath plans and issuers must publicly post a notice of these protections and include the notice with any EOB for an item or service to which the protections apply. The Departments issued a model notice that health plans and issuers may use (but are not required to use) to meet these disclosure requirements.	• Confirm the plan's issuer (or TPA for a self-insured plan) has posted the balance billing notice on a public website; • Review the written agreement with the issuer (or other third party) to ensure it addresses the issuer's (or TPA's) responsibility for posting this notice; and • Monitor the issuer's (or TPA's) compliance with this posting requirement.
Provide advanced EOBs *(delayed)*	Health plans and issuers must provide an advanced EOB to covered individuals after receiving a good-faith estimate of charges from a health care provider or facility. The requirement for health care providers and facilities to provide a good-faith estimate of	• Monitor guidance regarding the implementation of the advanced EOB requirement.

Disclosure Requirements		
Action Item	**Description**	**Key Compliance Steps**
	charges to health plans and issues has been indefinitely delayed. Thus, the Departments have also indefinitely delayed the requirement for plans and issuers to provide advanced EOBs until guidance is issued to implement these requirements.	