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Affordable Care Act (ACA) Transparency in Coverage Regulations

Public Disclosures		
Requirement	**Effective Date**	**Summary**
Public Disclosure – In-Network File	▪ Plan years starting on or after January 1, 2022 ▪ Deferred enforcement until July 1, 2022	▪ For each coverage option offered by a plan, the plan must provide: (i) the name and identifier (*e.g.*, HIOS); (ii) each billing code (*e.g.,* CPT) with a plain language description of the code; and (iii) all applicable rates, including negotiated rates, fee schedule rates, or derived amounts (*e.g.*, rates via reconciliation with providers or prices assigned for internal purposes). ▪ If a service is part of a bundled payment, a plan is permitted to disclose the total bundled dollar amount under a single billing code (if consistent with the actual reimbursement process) and list out all services and items included as part of the bundle.
Public Disclosure – Out-of-Network File	▪ Plan years starting on or after January 1, 2022 ▪ Deferred enforcement until July 1, 2022	▪ For each coverage option offered by a plan, the plan must provide: (i) the name and identifier; (ii) each billing code with a plain language description of the code; and (iii) unique out-of-network allowed amounts (as a dollar amount) for each out-of-network provider (with identifier; *e.g.*, NPI) and billed charges for services or items during the 90-day period beginning 180 days before the publication date of the file. ▪ Exception: Must omit this data if it relates to fewer than 20 different claims under a single plan or coverage option.
Public Disclosure – Prescription Drug File	▪ Plan years starting on or after January 1, 2022 ▪ Deferred enforcement indefinitely, pending further rulemaking	▪ For each coverage option offered by a plan, the plan must provide: (i) the name and identifier; (ii) the National Drug Code (NDC) from the U.S. Food and Drug Administration directory for each covered drug, along with each drug's proprietary and non-proprietary name; and (iii) the negotiated rate for each covered drug for each NDC. ▪ The negotiated rate must: (i) be reflected as a dollar amount for each NDC furnished to an in-network provider or other prescription drug dispenser; (ii) provide an identifier (*e.g.*, NPI) for each in-network provider; (iii) provide the last date of the contract term for each provider-specific negotiated rate that applies to each NDC; and (iv) historical net prices (*i.e.*, the retrospective average amount the plan paid for the drug inclusive of discounts, rebates, etc.) associated with the 90-day period beginning 180 days before the publication date of the file for each provider-specific rate.

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Participant Disclosures		
Requirement	**Effective Date**	**Summary**
Pre-Service "Explanation of Benefits" (EOB) Web Portal	▪ Plan years starting on or after January 1, 2023, for the 500 services and items listed by the U.S. Centers for Medicare & Medicaid Services ▪ Plan years starting on or after January 1, 2024, for all covered services and items	▪ Upon request, a plan must provide a pre-service EOB-like statement containing: (i) the member's cost-sharing liability for a requested service or item; (ii) the portion of the member's current accumulated cost-sharing liability (*e.g.*, deductible); (iii) the in-network rate (and underlying fee schedule rate, if different) for the specific service or item for an in-network provider; (iv) the out-of-network allowed amount (or percentage of billed charges) for the service or item for an out-of-network provider; (v) if a bundled service, a list of all items in the bundle; and (v) any prerequisites to coverage (*e.g.*, prior authorization). ▪ The information must be accurate as of the time it is requested (or reasonably accurate regarding out-of-network providers). ▪ The information must also include a notice containing statements regarding balance billing, copay assistance, preventive services, accuracy of estimate, and other appropriate disclaimers. ▪ The information must be available via a free self-service tool or internet website. The tool must allow for searching by billable code, name of in-network provider, and other factors utilized by the plan that are relevant for cost-sharing determinations (*e.g.*, facility name). The tool must be able to refine and reorder search results based on geographic proximity of in-network providers and the amount of the estimated cost-sharing liability. A paper form must be provided if requested.

Notes:

– *Does not apply to "grandfathered" health plans.*

– *Public disclosures must be in machine-readable files in a format specified by the regulatory agencies, and must be publicly available free of charge and without conditions (e.g., passwords). Files must be updated on a monthly basis.*

– *For fully-insured plans, the insurer (not the plan sponsor) will be liable, provided the plan requires the insurer to satisfy the requirements by written agreement. For self-funded plans, the plan sponsor remains liable even if contracted out to a third-party administrator (although the services contract may contain indemnification provisions).*

– *A plan will not fail to comply solely because it, acting in good faith and reasonable diligence, makes an error or omission, provided that it is corrected as soon as practicable. The same applies with respect to temporary inaccessibility of the tool.*

– *A plan will not fail to comply if it relied in good faith on information from the other entity unless the plan knows, or reasonably should have known, that the information was incomplete or inaccurate.*

Related Foley Articles

An Irony of Ironies – The Final ACA Price Transparency Rule (December 16, 2020)

Federal Departments Release Transparency in Coverage Final Rule (November 4, 2020)

Legal Authority

Transparency in Coverage, 85 Fed. Reg. 72158 (November 12, 2020)

Learn More

Nick J. Welle
Partner & Chair, Health Benefits Practice
Milwaukee

414.319.7185
nwelle@foley.com