

§ 147.211 Transparency in coverage—required disclosures to participants, beneficiaries, or enrollees.

(a) *Scope and definitions*—(1) *Scope*. This section establishes price transparency requirements for group health plans and health insurance issuers in the individual and group markets for the timely disclosure of information about costs related to covered items and services under a plan or health insurance coverage.

(2) *Definitions*. For purposes of this section, the definitions in § 147.210 apply.

(b) *Required disclosures to participants, beneficiaries, or enrollees*. At the request of a participant, beneficiary, or enrollee who is enrolled in a group health plan or health insurance issuer offering group or individual health insurance coverage, the plan or issuer must provide to the participant, beneficiary, or enrollee the information required under paragraph (b)(1) of this section, in accordance with the method and format requirements set forth in paragraph (b)(2) of this section.

(1) *Required cost-sharing information*. The information required under this paragraph (b)(1) is the following cost-sharing information, which is accurate at the time the request is made, with respect to a participant's, beneficiary's, or enrollee's cost-sharing liability for covered items and services:

(i) An estimate of the participant's, beneficiary's, or enrollee's cost-sharing liability for a requested covered item or service furnished by a provider or providers, which must reflect any cost-sharing reductions the enrollee would receive, that is calculated based on the information described in paragraphs (b)(1)(ii) through (iv) of this section.

(A) If the request for cost-sharing information relates to items and services that are provided within a bundled payment arrangement, and the bundled payment arrangement includes items or services that have a separate cost-sharing liability, the group health plan or health insurance issuer must provide estimates of the cost-sharing liability for the requested covered item or service, as well as an estimate of the cost-sharing liability for each of the items and services in the bundled payment arrangement that have separate

cost-sharing liabilities. While group health plans and health insurance issuers are not required to provide estimates of cost-sharing liability for a bundled payment arrangement where the cost-sharing is imposed separately for each item and service included in the bundled payment arrangement, nothing prohibits plans or issuers from providing estimates for multiple items and services in situations where such estimates could be relevant to participants or beneficiaries, as long as the plan or issuer also discloses information about the relevant items or services individually, as required in paragraph (b)(1)(v) of this section.

(B) For requested items and services that are recommended preventive services under section 2713 of the Public Health Service Act (PHS Act), if the group health plan or health insurance issuer cannot determine whether the request is for preventive or non-preventive purposes, the plan or issuer must display the cost-sharing liability that applies for non-preventive purposes. As an alternative, a group health plan or health insurance issuer may allow a participant, beneficiary, or enrollee to request cost-sharing information for the specific preventive or non-preventive item or service by including terms such as "preventive", "non-preventive" or "diagnostic" as a means to request the most accurate cost-sharing information.

(ii) Accumulated amounts.

(iii) In-network rate, comprised of the following elements, as applicable to the group health plan's or health insurance issuer's payment model:

(A) Negotiated rate, reflected as a dollar amount, for an in-network provider or providers for the requested covered item or service; this rate must be disclosed even if it is not the rate the plan or issuer uses to calculate cost-sharing liability; and

(B) Underlying fee schedule rate, reflected as a dollar amount, for the requested covered item or service, to the extent that it is different from the negotiated rate.

(iv) Out-of-network allowed amount or any other rate that provides a more accurate estimate of an amount a group health plan or health insurance

issuer will pay for the requested covered item or service, reflected as a dollar amount, if the request for cost-sharing information is for a covered item or service furnished by an out-of-network provider; provided, however, that in circumstances in which a plan or issuer reimburses an out-of-network provider a percentage of the billed charge for a covered item or service, the out-of-network allowed amount will be that percentage.

(v) If a participant, beneficiary, or enrollee requests information for an item or service subject to a bundled payment arrangement, a list of the items and services included in the bundled payment arrangement for which cost-sharing information is being disclosed.

(vi) If applicable, notification that coverage of a specific item or service is subject to a prerequisite.

(vii) A notice that includes the following information in plain language:

(A) A statement that out-of-network providers may bill participants, beneficiaries, or enrollees for the difference between a provider's billed charges and the sum of the amount collected from the group health plan or health insurance issuer and from the participant, beneficiary, or enrollee in the form of a copayment or coinsurance amount (the difference referred to as balance billing), and that the cost-sharing information provided pursuant to this paragraph (b)(1) does not account for these potential additional amounts. This statement is only required if balance billing is permitted under state law;

(B) A statement that the actual charges for a participant's, beneficiary's, or enrollee's covered item or service may be different from an estimate of cost-sharing liability provided pursuant to paragraph (b)(1)(i) of this section, depending on the actual items or services the participant, beneficiary, or enrollee receives at the point of care;

(C) A statement that the estimate of cost-sharing liability for a covered item or service is not a guarantee that benefits will be provided for that item or service;

(D) A statement disclosing whether the plan counts copayment assistance and other third-party payments in the

calculation of the participant's, beneficiary's, or enrollee's deductible and out-of-pocket maximum;

(E) For items and services that are recommended preventive services under section 2713 of the PHS Act, a statement that an in-network item or service may not be subject to cost-sharing if it is billed as a preventive service if the group health plan or health insurance issuer cannot determine whether the request is for a preventive or non-preventive item or service; and

(F) Any additional information, including other disclaimers, that the group health plan or health insurance issuer determines is appropriate, provided the additional information does not conflict with the information required to be provided by this paragraph (b)(1).

(2) *Required methods and formats for disclosing information to participants, beneficiaries, or enrollees.* The methods and formats for the disclosure required under this paragraph (b) are as follows:

(i) *Internet-based self-service tool.* Information provided under this paragraph (b) must be made available in plain language, without subscription or other fee, through a self-service tool on an internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request. Group health plans and health insurance issuers must ensure that the self-service tool allows users to:

(A) Search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers by inputting:

(1) A billing code (such as CPT code 87804) or a descriptive term (such as "rapid flu test"), at the option of the user;

(2) The name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider; and

(3) Other factors utilized by the plan or issuer that are relevant for determining the applicable cost-sharing information (such as location of service, facility name, or dosage).

(B) Search for an out-of-network allowed amount, percentage of billed

charges, or other rate that provides a reasonably accurate estimate of the amount a group health plan or health insurance issuer will pay for a covered item or service provided by out-of-network providers by inputting:

(1) A billing code or descriptive term, at the option of the user; and

(2) Other factors utilized by the plan or issuer that are relevant for determining the applicable out-of-network allowed amount or other rate (such as the location in which the covered item or service will be sought or provided).

(C) Refine and reorder search results based on geographic proximity of in-network providers, and the amount of the participant's, beneficiary's, or enrollee's estimated cost-sharing liability for the covered item or service, to the extent the search for cost-sharing information for covered items or services returns multiple results.

(ii) *Paper method.* Information provided under this paragraph (b) must be made available in plain language, without a fee, in paper form at the request of the participant, beneficiary, or enrollee. In responding to such a request, the group health plan or health insurance issuer may limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per request. The group health plan or health insurance issuer is required to:

(A) Disclose the applicable provider-per-request limit to the participant, beneficiary, or enrollee;

(B) Provide the cost-sharing information in paper form pursuant to the individual's request, in accordance with the requirements in paragraphs (b)(2)(i)(A) through (C) of this section; and

(C) Mail the cost-sharing information in paper form no later than 2 business days after an individual's request is received.

(D) To the extent participants, beneficiaries, and enrollees request disclosure other than by paper (for example, by phone or email), plans and issuers may provide the disclosure through another means, provided the participant, beneficiary, or enrollee agrees that disclosure through such means is sufficient to satisfy the request and the re-

quest is fulfilled at least as rapidly as required for the paper method.

(3) *Special rule to prevent unnecessary duplication—*(i) *Special rule for insured group health plans.* To the extent coverage under a group health plan consists of group health insurance coverage, the plan satisfies the requirements of this paragraph (b) if the plan requires the health insurance issuer offering the coverage to provide the information required by this paragraph (b) in compliance with this section pursuant to a written agreement. Accordingly, if a health insurance issuer and a plan sponsor enter into a written agreement under which the issuer agrees to provide the information required under this paragraph (b) in compliance with this section, and the issuer fails to do so, then the issuer, but not the plan, violates the transparency disclosure requirements of this paragraph (b).

(ii) *Other contractual arrangements.* A group health plan or health insurance issuer may satisfy the requirements under this paragraph (b) by entering into a written agreement under which another party (such as a pharmacy benefit manager or other third-party) provides the information required by this paragraph (b) in compliance with this section. Notwithstanding the preceding sentence, if a group health plan or health insurance issuer chooses to enter into such an agreement and the party with which it contracts fails to provide the information in compliance with this paragraph (b), the plan or issuer violates the transparency disclosure requirements of this paragraph (b).

(c) *Applicability.* (1) The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after January 1, 2023 with respect to the 500 items and services to be posted on a publicly available website, and with respect to all covered items and services, for plan years (in the individual market, for policy years) beginning on or after January 1, 2024.

(2) As provided under §147.140, this section does not apply to grandfathered health plans. This section also does not apply to health reimbursement arrangements or other account-based

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group health plans as defined in § 147.126(d)(6) or short term limited duration insurance as defined in 45 CFR 144.103.

(3) Nothing in this section alters or otherwise affects a group health plan's or health insurance issuer's duty to comply with requirements under other applicable state or Federal laws, including those governing the accessibility, privacy, or security of information required to be disclosed under this section, or those governing the ability of properly authorized representatives to access participant, beneficiary, or enrollee information held by plans and issuers.

(4) A group health plan or health insurance issuer will not fail to comply with this section solely because it, acting in good faith and with reasonable diligence, makes an error or omission in a disclosure required under paragraph (b) of this section, provided that the plan or issuer corrects the information as soon as practicable.

(5) A group health plan or health insurance issuer will not fail to comply with this section solely because, despite acting in good faith and with reasonable diligence, its internet website is temporarily inaccessible, provided that the plan or issuer makes the information available as soon as practicable.

(6) To the extent compliance with this section requires a group health plan or health insurance issuer to obtain information from any other entity, the plan or issuer will not fail to comply with this section because it relied in good faith on information from the other entity, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate.

(d) *Severability.* Any provision of this section held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, shall be severable from this section and shall not affect the remainder thereof or the application of the provision to persons not similarly situated or to dissimilar circumstances.

[85 FR 72305, Nov. 12, 2020]

45 CFR Subtitle A (10–1–23 Edition)

§ 147.212 Transparency in coverage—requirements for public disclosure.

(a) *Scope and definitions*—(1) *Scope.* This section establishes price transparency requirements for group health plans and health insurance issuers in the individual and group markets for the timely disclosure of information about costs related to covered items and services under a plan or health insurance coverage.

(2) *Definitions.* For purposes of this section, the definitions in § 147.210 apply.

(b) *Requirements for public disclosure of in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs.* A group health plan or health insurance issuer must make available on an internet website the information required under paragraph (b)(1) of this section in three machine-readable files, in accordance with the method and format requirements described in paragraph (b)(2) of this section, and that are updated as required under paragraph (b)(3) of this section.

(1) *Required information.* Machine-readable files required under this paragraph (b) that are made available to the public by a group health plan or health insurance issuer must include:

(i) An in-network rate machine-readable file that includes the required information under this paragraph (b)(1)(i) for all covered items and services, except for prescription drugs that are subject to a fee-for-service reimbursement arrangement, which must be reported in the prescription drug machine-readable file pursuant to paragraph (b)(1)(iii) of this section. The in-network rate machine-readable file must include:

(A) For each coverage option offered by a group health plan or health insurance issuer, the name and the 14-digit Health Insurance Oversight System (HIOS) identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or if no HIOS identifier is available, the Employer Identification Number (EIN);

(B) A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for