FAQ ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 65

February 2, 2024

Set out below is a Frequently Asked Question (FAQ) regarding implementation of certain provisions of the Affordable Care Act (ACA). This FAQ has been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), this FAQ answers questions from stakeholders to help people understand the law and promote compliance.

Transparency in Coverage

The Transparency in Coverage Final Rules (TiC Final Rules) require non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to make cost-sharing information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request.[1] This information must be made available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the Departments in Table 1 of the preamble to the TiC Final Rules,[2] and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.[3]

The plan or issuer must make such information available to a participant, beneficiary, or enrollee upon request for a discrete covered item or service by billing code or descriptive term, and generally must furnish it according to the participant's, beneficiary's, or enrollee's request.[4] Specifically, the TiC Final Rules require a plan or issuer to provide cost-sharing information for a covered item or service in connection with an in-network provider or providers, or an out-of-network allowed amount for a covered item or service provided by an out-of-network provider or providers, according to the participant's, beneficiary's, or enrollee's request, permitting the individual to specify the information necessary for the plan or issuer to provide meaningful cost-

[1] 26 CFR 54.9815-2715A2(b); 29 CFR 2590.715-2715A2(b); and 45 CFR 147.211(b). The Consolidated Appropriations Act, 2021 imposed a largely duplicative requirement and added a requirement that the information also be provided by telephone, upon request. *See also* FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021), Q3, *available at* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf.

[2] 85 FR 72158, 72182-90 (Nov. 12, 2020).

[3] 26 CFR 54.9815-2715A2(c)(1); 29 CFR 2590.715-2715A2(c)(1); and 45 CFR 147.211(c)(1).

[4] In responding to a participant, beneficiary, or enrollee's request for such information in paper form, 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. 26 CFR 54.9815-2715A2(b)(2)(ii); 29 CFR 2590.715-2715A2(b)(2)(ii); and 45 CFR 147.211(b)(2)(ii).

sharing liability information(such as dosage for a prescription drug or zip code for an out-of-network allowed amount).[5]

Additionally, the TiC Final Rules require non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to disclose on a public website information regarding 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 in three separate machine-readable files.[6] The machine-readable file requirements of the TiC Final Rules are applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

As set forth in the TiC Final Rules, the cost-sharing disclosure for an item or service in the internet-based self-service tool must be an accurate estimate at the time the request is made.[7] These estimates are primarily based on contracted rates; however, the Departments stated in the preamble to the TiC Final Rules that plans and issuers may use advanced analytics such as past claims data to produce more accurate cost estimates.[8] In cases where rates for items and services are not negotiated as prospective dollar rates—for example, in percentage-of-billed-charges arrangements—cost estimates may be based only on past claims data. Occasionally, past data may be limited for items or services with very low utilization and therefore may result in less predictive and less accurate cost estimates.

Q1: How should plans and issuers comply with the cost-sharing disclosure requirements of the TiC Final Rules with regard to items and services with extremely low utilization when a cost estimate is based on claims data rather than prospective rates?

The Departments recognize that in certain, limited circumstances, plans and issuers may not be able to provide accurate cost-sharing estimates as required by the TiC Final Rules for items and services with extremely low utilization rates. To ensure that consumers receive accurate cost-sharing information, the Departments are likely to exercise their discretion, on a case-by-case basis, not to bring enforcement actions against plans and issuers that fail to include in their self-service tool (or in paper form, upon request) or fail to provide over the phone cost-sharing information for items and services for which a cost estimate for such items and services would need to be based on past claims data[9] and for which there have been fewer than 20 different claims[10] in total over the past three years. For these items and services, the plan or issuer should

[5] 26 CFR 54.9815-2715A2(b)(1); 29 CFR 2590.715-2715A2(b)(1); and 45 CFR 147.211(b)(1).
[6] 85 FR 72158 (Nov. 12, 2020). *See also* FAQs About Affordable Care Act Implementation Part 61 (Sept. 27, 2023), Q1, *available at* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-61 and https://www.cms.gov/files/document/faqs-about-affordable-care-act-implementation-part-61.pdf.
[7] 26 CFR 54.9815-2715A2(b)(1); 29 CFR 2590.715-2715A2(b)(1); and 45 CFR 147.211(b)(1).
[8] 85 FR 72158, 72191.
[9] For example, in cases where payment for such item or service and consumer liability is determined retrospectively, as with rates based on a percentage of billed charges and where cost-sharing is based on a percentage of those charges.
[10] In determining whether this 20 different claim threshold is met, health insurance issuers, service providers, or other parties with which a group health plan or issuer has entered into a written or other contractual agreement as

indicate on the self-service tool that the item or service is covered, but that a specific cost estimate is not available pursuant to the TiC Final Rules because of insufficient data. The self-service tool should encourage the participant, beneficiary, or enrollee to contact the plan or issuer for more information on the item's or service's cost-sharing requirements. In cases where the participant, beneficiary, or enrollee contacts a plan or issuer to request such information, the Departments encourage the plan or issuer to provide any available relevant benefits information, such as information available on the Summary of Benefits and Coverage or the portion of the cost of the item or service for which the participant, beneficiary, or enrollee will be responsible. The Departments remind plans and issuers that cost-sharing information for all other covered items and services must be made available through a self-service tool (and in paper form, upon request) as well as over the phone.

provided under 26 CFR 54.9815-2715A2(b)(3), 29 CFR 2590.715-2715A2(b)(3), and 45 CFR 147.211(b)(3) may aggregate claims for items and services for more than one plan or insurance policy or contract in a manner consistent with how the issuer, service provider, or party uses claims data to support the self-service tool.