

45 CFR § 147.212 - Transparency in coverage—requirements for public disclosure.

§ 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 each [billing code](#) for each covered item or service under each coverage option offered by a [plan](#) or [issuer](#); and

(C) All applicable rates, which may include one or more of the following: Negotiated rates, underlying fee schedule rates, or derived amounts. If a group health [plan](#) or [health insurance issuer](#) does not use negotiated rates for provider reimbursement, then the [plan](#) or [issuer](#) should disclose derived amounts to the extent these amounts are already calculated in the normal course of business. If the group health [plan](#) or [health insurance issuer](#) uses underlying fee schedule rates for calculating cost sharing, then the [plan](#) or [issuer](#) should include the underlying fee schedule rates in addition to the [negotiated rate](#) or derived amount. Applicable rates, including for both individual items and services and items and services in a bundled payment arrangement, must be:

(1) Reflected as dollar amounts, with respect to each covered item or service that is furnished by an [in-network provider](#). If the [negotiated rate](#) is subject to change based upon [participant](#), beneficiary, or enrollee-specific characteristics, these dollar amounts should be reflected as the base [negotiated](#)

[rate](#) applicable to the item or service prior to adjustments for [participant](#), beneficiary, or enrollee-specific characteristics;

(2) Associated with the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code for each [in-network provider](#);

(3) Associated with the last date of the contract term or expiration date for each provider-specific applicable rate that applies to each covered item or service; and

(4) Indicated with a notation where a reimbursement arrangement other than a standard fee-for-service model (such as capitation or a bundled payment arrangement) applies.

(ii) An [out-of-network allowed amount machine-readable file](#), including:

(A) For each coverage option offered by a group health [plan](#) or [health insurance issuer](#), the name and the 14-digit 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 EIN;

(B) A [billing code](#), which in the case of prescription drugs must be an NDC, and a plain language description for each [billing code](#) for each covered item or service under each coverage option offered by a [plan](#) or [issuer](#); and

(C) Unique out-of-network allowed amounts and billed charges with respect to covered items or services furnished by [out-of-network providers](#) during the 90-day time period that begins 180 days prior to the publication date of the [machine-readable file](#) (except that a group health [plan](#) or [health insurance issuer](#) must omit such data in relation to a particular item or service and provider when compliance with this paragraph (b)(1)(ii)(C) would require the [plan](#) or [issuer](#) to report payment of out-of-network allowed amounts in connection with fewer than 20 different claims for payments under a single [plan](#) or coverage). Consistent with [paragraph \(c\)\(3\)](#) of this section, nothing in this paragraph (b)(1)(ii)(C) requires the [disclosure](#) of information that would violate any applicable health information privacy law. Each unique [out-of-network allowed amount](#) must be:

(1) Reflected as a dollar amount, with respect to each covered item or service that is furnished by an [out-of-network provider](#); and

(2) Associated with the NPI, TIN, and Place of Service Code for each [out-of-network provider](#).

(iii) A prescription drug [machine-readable file](#), including:

(A) For each coverage option offered by a group health [plan](#) or [health insurance issuer](#), the name and the 14-digit 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 EIN;

(B) The NDC, and the proprietary and nonproprietary name assigned to the NDC by the Food and Drug Administration (FDA), for each covered item or service that is a prescription drug under each coverage option offered by a [plan](#) or [issuer](#);

(C) The negotiated rates which must be:

(1) Reflected as a dollar amount, with respect to each NDC that is furnished by an [in-network provider](#), including an in-network pharmacy or other prescription drug dispenser;

(2) Associated with the NPI, TIN, and Place of Service Code for each [in-network provider](#), including each in-network pharmacy or other prescription drug dispenser; and

(3) Associated with the last date of the contract term for each provider-specific [negotiated rate](#) that applies to each NDC; and

(D) [Historical net prices](#) that are:

(1) Reflected as a dollar amount, with respect to each NDC that is furnished by an [in-network provider](#), including an in-network pharmacy or other prescription drug dispenser;

(2) Associated with the NPI, TIN, and Place of Service Code for each [in-network provider](#), including each in-network pharmacy or other prescription drug dispenser; and

(3) Associated with the 90-day time period that begins 180 days prior to the publication date of the [machine-readable file](#) for each provider-specific [historical net price](#) that applies to each NDC (except that a group health [plan](#) or [health insurance issuer](#) must omit such data in relation to a particular NDC and provider when compliance with this paragraph (b)(1)(iii)(D) would require the [plan](#) or [issuer](#) to report payment of [historical net prices](#) calculated using fewer than 20 different claims for payment). Consistent with [paragraph \(b\)\(3\)](#) of this section, nothing in this paragraph (b)(1)(iii)(D) requires the [disclosure](#) of information that would violate any applicable health information privacy law.

(2) Required method and format for disclosing information to the public. The [machine-readable files](#) described in this paragraph (b) must be available in a form and manner as specified in guidance issued by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services. The [machine-readable files](#) must be publicly available and accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of [personally identifiable information](#) to access the file.

(3) Timing. A group health [plan](#) or [health insurance issuer](#) must update the [machine-readable files](#) and information required by this paragraph (b) monthly. The group health [plan](#) or [health insurance issuer](#) must clearly indicate the date that the files were most recently updated.

(4) Special rules 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 pursuant to a written agreement. Accordingly, if a [health insurance issuer](#) and a group health [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 third-party administrator or health care claims clearinghouse) will provide 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).

(iii) Aggregation permitted for out-of-network allowed amounts. Nothing in this section prohibits a group health [plan](#) or [health insurance issuer](#) from satisfying the [disclosure](#) requirement described in [paragraph \(b\)\(1\)\(ii\)](#) of this section by disclosing out-of-network allowed amounts made available by, or otherwise obtained from, an [issuer](#), a service provider, or other party with which the [plan](#) or [issuer](#) has entered into a written agreement to provide the information, provided the minimum claim threshold described in [paragraph \(b\)\(1\)\(ii\)\(C\)](#) of this section is independently met for each item or service and for each [plan](#) or coverage included in an aggregated Allowed Amount File. Under such circumstances, health insurance [issuers](#), service providers, or other parties with which the group health [plan](#) or [issuer](#) has contracted may aggregate out-of-network allowed amounts for more than one [plan](#) or insurance policy or contract. Additionally, nothing in this section prevents the Allowed Amount File from being hosted on a third-party website or prevents a [plan](#) administrator or [issuer](#) from contracting with a third party to post the file. However, if a [plan](#) or [issuer](#) chooses not to also host the file separately on its own website, it must provide a link on its own public website to the location where the file is made publicly available.

(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, 2022.

(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 group health [plans](#) as defined in [§ 147.126\(d\)\(6\)](#) or short term limited duration insurance as defined in [§ 144.103](#) of this subchapter.

(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](#), or beneficiary 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]