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New Transparency in Pricing Rules Require Health Insurers to Disclose Health Care Cost and Cost-Sharing Information

On October 29, 2020, the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury (the “Departments”) released a [new rule](#) requiring group health plans and health insurance issuers in the individual and group markets to disclose cost-sharing information upon request to a participant, beneficiary, or enrollee for covered items or services furnished by a particular provider. This rule is consistent with the goals laid out in President Trump’s executive order, “Improving Price and Quality Transparency in American Healthcare to Put Patients First.”

The new rule builds upon previous rules and executive actions taken by the Trump administration regarding price transparency for patients to access hospital pricing information. The Departments [have already finalized requirements](#) for hospitals to disclose their standard charges, including negotiated rates with third-party payers, which take effect on January 1, 2021. The requirements in this final rule will increase transparency in healthcare pricing with the goal of bringing increased competition and lower prices to the private health care industry.

The insurance pricing transparency final rule has three major aspects to making pricing information more available for consumers while incentivizing consumers to shop for services from lower-cost, higher-value providers.

Required Disclosures to Participants

Most non-grandfathered group health plans, health insurance issuers offering coverage in the individual and group markets, and employer self-funded plans will be required to make new additional information regarding the costs of items and services available to the insureds. These disclosures will be made on an internet-based,

self-service tool that consumers may access or request in paper form. The information must be searchable by billing code, name of provider, and other factors that may affect cost-sharing liability. The required disclosures must include:

- The underlying negotiated rates for all covered health care items and services, including prescription drugs, for both in-network and out-of-network providers.
- The estimated cost-sharing liability for the insured.
- The accumulated amounts the insured has already paid towards the plan's deductible or out-of-pocket maximum.
- If the item or service requested is part of a bundled payment, a list of items or services included in the bundle for which cost-sharing information is provided.
- A notice if there are any requirements prior to obtaining coverage.

An initial list of 500 shoppable services, as determined by the Departments, will be required to be available on the self-service tool for plan years that begin on or after January 1, 2023. All other items and services will be required for these self-service tools for plan years that begin on or after January 1, 2024.

It is also important to note that a self-funded plan can delegate this responsibility to a benefit plan administrator or "third party administrator." While the plan will still be responsible for any liability associated with non-compliance, the new rule does include a safe harbor provision for plans acting in good faith.

Required Public Disclosures

Applicable issuers and plans will also be required to make available to the public three separate machine-readable files that include detailed pricing information. Individuals should be able to access the files without having to log in or otherwise submit identifying information. The three separate files will contain:

- The negotiated rates for all covered items and services between the plan or issuer and in-network providers.

- The historical payments to, and billed charges from, out-of-network providers.
- The in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

Issuers must display these data files in a standardized format and provide monthly updates beginning on January 1, 2022.

Shared Savings in MLR

Lastly, this rule finalizes amendments to its medical loss ratio (MLR) program rules to allow issuers to receive credit in their MLR calculations for savings they share with enrollees that result from the enrollees shopping for, and receiving care from, lower-cost, higher-value providers. If an issuer's design results in savings for the consumer, issuers can share in those savings by taking credit for "shared savings" in the numerator of their MLR calculation. Therefore, issuers will not be required to pay MLR rebates based on a plan design that provides a benefit to consumers that is not currently captured in any existing MLR revenue or expense category.

The final rule provides some examples of how these plan designs may work to provide additional shared savings. Under some plan designs, the savings are calculated as a percentage of the difference between the rate charged by the provider chosen by the consumer for a medical procedure and the average negotiated rate for that procedure across all providers in the issuer's network. Under other plan designs, the "shared savings" are provided as a flat dollar amount according to a schedule that places providers in one or more tiers based on the rate charged by each provider for a specified medical procedure.

The "shared savings" may be provided in the form of a gift card, a reduction in cost sharing, or a premium credit to the insured. The Departments believe this approach preserves the value consumers receive for coverage under the MLR program, while also encouraging issuers to offer innovative designs that encourage both competition and consumer engagement in health care.

If you have questions about the final rule or any other regulatory requirements, Frost Brown Todd's [Insurance Regulation & Risk Management](#), [Employee Benefits](#), or [Health Care Innovation](#) teams can help.

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