Health Cost Transparency Guide for Employers

A practical guide to understanding health cost transparency rules

Version 2, Updated August 2022

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OVERVIEW

Background

The Consolidated Appropriations Act (CAA), No Surprises Act (NSA), and the Transparency in Coverage Final Rule (TiC Final Rule) impose several new requirements on employer sponsored group health plans. A list of the various rules is included Section 1. This guide will focus on the portion of the new rules that we will refer to as the "Transparency Requirements."

The goal of the Transparency Requirements is to make it easier to understand, and have access to, what medical services cost, and what health plans pay for those services. Historically, it has been very difficult, if not impossible, to find out what most health care services will cost in advance. As the various Transparency Requirements begin to come into force over the next few years, access to much more detailed information regarding health care costs will help consumers and businesses become better buyers of health care services.

While the Transparency Requirements may seem overwhelming at times, employers will find that in most cases they will be relying on their insurance carriers, administrators, and other vendors to do most of the heavy lifting. This guide is designed to help employers understand their role and navigate their compliance responsibilities. The guide will be regularly updated as additional regulations and guidance is issued.

What Plans are Subject to the Transparency Requirements?

The Transparency Requirements apply to health insurance issuers ("issuer" is how the regulatory agencies refer to health insurance carriers, we will use the term "carrier" in this guide) and most group health plans, including non-federal governmental plans (e.g., cities, public schools, etc.), multiemployer plans (i.e., Taft Hartley plans) and multiple employer plans. The requirements do not apply to account-based plans such as an HRA, nor to excepted benefits (e.g., stand-alone dental and vision plans, EAPs, etc.).

The TiC Final Rule carves out an exception for grandfathered health plans, but the CAA does not. Due to overlap between the TiC Final Rule and the CAA, it appears that all Transparency Requirements may apply to grandfathered plans other than the requirement to post machine-readable files.

Employer Compliance Roadmap

Section 1 – Understand the effective dates and compliance deadlines of the various requirements

Section 2 – Understand who is responsible for compliance with each of the rules

Section 3 – Prepare for the health plan cost machine readable file requirement going into effect beginning July 1, 2022

Section 4 – Prepare for the prescription drug cost reporting requirement beginning December 27, 2022

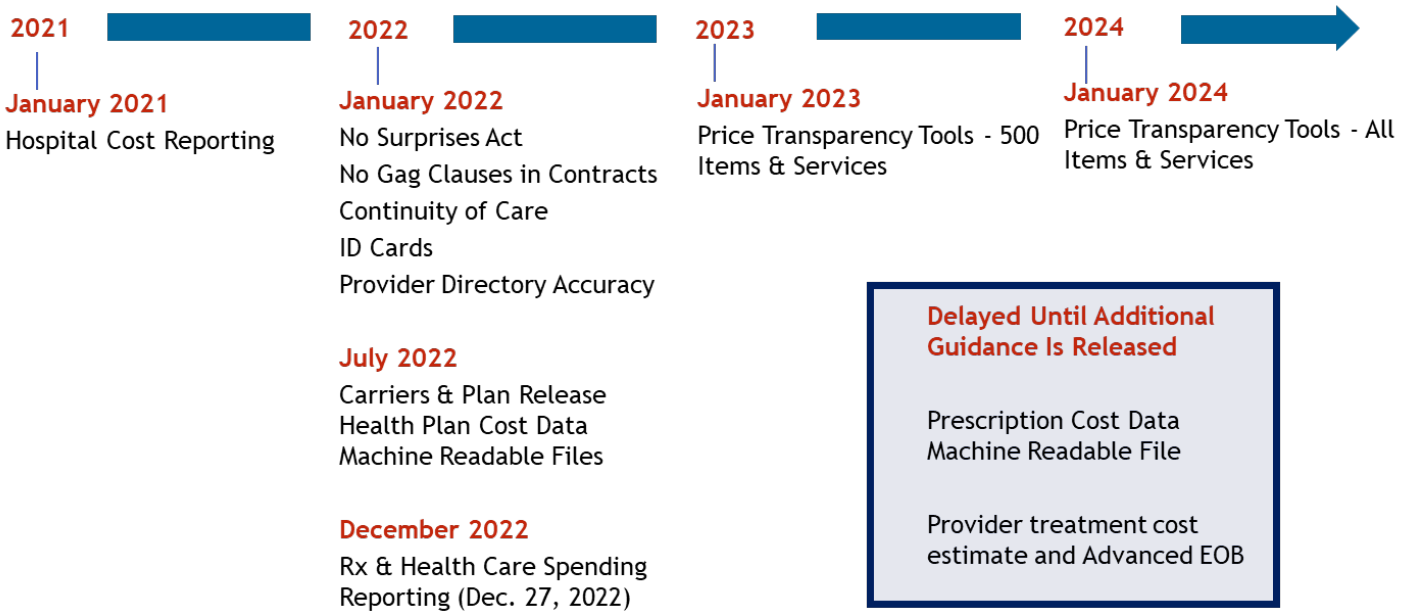
Section 5 – Begin to prepare for making the pricing tool available to participants beginning January 2023

Section 6 – Understand other requirements that will go into effect later depending on new guidance

A Note about the Hospital Cost Data Files

While not part of this guide, it is interesting to note that the first stage of health cost transparency effort began January 1, 2021, when hospitals were required to publicly post data on what they charge different payers for various medical services. Compliance with this requirement has been mixed, with some hospitals still not making the required information available. However, as more hospitals come into compliance, the industry is already learning much more about how hospitals price their services than has been known before.

Section 1 - Summary of Requirements & Timeline of Effective Dates



2021

- **Hospital Cost Data -** Effective January 1, 2021, hospitals were required to make publicly available data containing charges for all items and services provided by the hospital. Hospitals must also publish a consumer-friendly list for the hospital's 300 most "shoppable services."

2022

- **No Surprises Act** – Effective for plan years beginning January 1, 2022, balance billing protection for claims related to out-of-network emergency services, out-of-network providers in an in-network facility, and air ambulance claims.
- **Gag Clauses Prohibited** – Effective in 2022, carriers and health plans must submit an annual attestation of compliance with the prohibition on gag clauses in provider reimbursement contracts that took effect in 2020.
- **Continuity of Care** - Effective January 1, 2022, certain participants can request 90 days of in-network coverage when a provider leaves the network.
- **ID Card Requirements** - Effective January 1, 2022, ID cards must include additional information, including deductible and copay details.
- **Health Plan Machine Readable Data Files** - Effective July 1, 2022, for plan year data beginning January 1, 2022, carriers and health plans are required to publicly disclose machine-readable files detailing reimbursement rates for in-network providers and allowed amounts for out-of-network covered items and services. An additional requirement to post prescription drug reimbursement data is delayed pending additional guidance.
- **Prescription Drug Cost Reporting** - Effective December 27, 2022, carriers and health plans are required to annually report prescription drug costs and other plan information.

2023 - 2024

- **Advanced Cost Estimate "Price Comparison Tools"** - Carriers and health plans are required to develop and make available an internet-based, self-service tool for comparing the prices of items and services. The information must also be available in paper form upon request, as well as via telephone.
    - 500 items and services for plan years effective January 2023
    - All covered items and services for plan years effective January 2024

Delayed Pending Additional Guidance

- **Advanced Explanation of Benefits (EOB)** - Health care providers will be required to provide an advance good faith estimate to a carrier or health plan when a patient seeks care. The carrier or health plan will then need to provide an advanced EOB to the individual.

Section 2 - Who is Responsible for Compliance?

Multiple Stakeholders Will Be Involved

Many of the requirements discussed in this guide involve data and information not readily available to the typical employer/plan sponsor. For example, the health plan cost data machine-readable files must include reimbursement data specific to the provider agreements between the carrier or network and a particular medical provider. This information is contained in the provider agreements between the carrier or network and the provider that, until now, have been confidential. So obviously, employers will need to rely on their carriers and vendors to do much of what is required by the various rules. However, just because the employer will need to rely on its vendors does not mean they can simply ignore the Transparency Requirements. Actual responsibility for compliance in most cases will depend on whether the employer's plan is fully insured or self-insured.

Compliance Responsibility Based on Plan Type

Compliance responsibility is addressed in more detail in each section, but at a high-level, employers should think of it this way:

Fully-Insured Plans

In most cases, employers who sponsor fully-insured plans will be able to rely on the carrier for compliance. In fact, most of the rules discussed in this guide specifically make the carrier responsible for compliance. Some of the Transparency Requirements may require that the employer enter into a "written agreement" with the carrier, but the exact form of that written agreement is not defined. Most carriers have taken the position that existing language in the group contract that clarifies that the carrier is responsible for complying with all applicable laws and regulations, along with communications they have sent to their clients in the form of emails and FAQs, is enough. At a minimum, fully-insured employers should have a discussion with their carrier regarding compliance with these rules.

Self-Insured Plans

The issue is more complicated for employers who sponsor self-insured plans. In this case, technically, the employer is usually the entity that is liable for the compliance of their plan. This is even the case when, from a practical perspective, most of the responsibility will fall on the shoulders of the administrator or other vendor.

Employers who sponsor self-insured plans will need to ensure that their vendors are fulfilling their obligations so that the employer's plan is in compliance with the rules. For this purpose:

- Employers/Plan Sponsors should reach out to their vendors to discuss their plans for compliance and ask for written assurances.

- Service agreements and contracts should be reviewed and amended as necessary to ensure that the administrator or other vendor is taking the necessary steps to comply with the applicable rules.
- Employers should ask vendors if there will be any additional costs related to compliance with these rules.
- Indemnification language in existing contracts should be reviewed and updated, if necessary, to protect the employer in cases where a vendor is not able to comply with a rule or regulation.

A Note about Vendor Compliance

Many of the Transparency Requirements require vendors to implement very significant technical and administrative changes, and not all vendors will get everything exactly right from the beginning. Even the regulatory agencies recognize this in comments made in the preambles to various regulations. While employers need to hold their vendors accountable, at the same time they should recognize that this is a process that may take some time to work itself out. It is expected that the regulatory agencies' approach to enforcement in the beginning will be to try to help the industry implement these rules rather than penalizing those who are making a good faith attempt to comply.

Section 3 - Health Plan Cost Disclosure: The "Machine Readable Files"

Background

Under the TiC Final Rule, effective July 1, 2022, health plans (which include employer sponsored health plans) and carriers must publicly post pricing data known as the "machine-readable files" or "MRFs." The point of releasing these cost data files has nothing to do with communication to employees or plan participants. Instead, in the name of health cost transparency, this rule requires insurance companies and self-insured plans to publicize what they pay providers for medical services and make that information available to the public. One of the primary goals with this requirement is that the information can then be gathered broadly, and data analytics can be run to provide more cost transparency across the industry.

Fully-insured plans may generally rely on the carrier to handle this requirement on behalf of the plan. However, for employers offering self-insured plans, the employer may be required to post a link to such file on the employer's public website.

Effective Date

The applicable files should be available July 1, 2022, for any plan years beginning January 1 through July 1, 2022. For plan years beginning after July 1, 2022, the files should be made available during the first month of the plan year. For example, a plan with a plan year start date of September 1, 2022, should make the files available no later than September 30, 2022. Note that some carriers and administrators may be posting data files by July 1, 2022 for all plans, even those with later effective dates. There is no problem with a plan making a data file available prior to its actual deadline.

Posting Requirements

Carriers and plans are required to publicly disclose in a machine-readable file the following reimbursement rate:

- In-network provider rates for covered items and services; and
- Out-of-network allowed amounts for covered items and services.

The TiC Final Rule requires the machine-readable files to be accessible free of charge, without having to establish a user account, password, or other credentials, and without having to submit any personal identifying information such

as a name or email address (see Treas. Reg. §54.9815-2715A3(b)(2)). Along with the link, some carriers are recommending overview verbiage such as the following:

This link leads to the machine-readable files that are made available in response to the federal Transparency in Coverage Rule and includes negotiated service rates and out-of-network allowed amounts between health plans and healthcare providers. The machine-readable files are formatted to allow researchers, regulators, and application developers to access and analyze data more easily.

Creating, hosting, and linking to the machine-readable files is just one part of the overall requirements. The machine-readable files must be updated monthly (and clearly indicate the date the filed was last updated) and must be available in a form and manner specified in any guidance issued by applicable regulatory agencies.

Compliance Responsibility

Carriers and administrators have begun to issue communications outlining how they plan to meet these requirements. One of the requirements of particular interest to employers is that the data must be posted on a publicly available website. Carriers and administrators have interpreted this requirement differently, creating some confusion among employers. Based on the information currently available, we are recommending that employers be prepared to do the following:

- **Fully-Insured Plans**: Employers sponsoring fully-insured medical plan options can rely on the carrier to satisfy this requirement. The TiC Final Rule specifically states that if the employer has a "written agreement" with the carrier indicating that the carrier is posting the information, then the employer does not need to take further action. There is no guidance on what constitutes a written agreement, but most carriers are providing a communication to their employer clients confirming their plans to make the required data available. Employers can likely rely on these carrier communications pending further guidance.
- **Self-Insured Plans**: Employers sponsoring self-insured medical plans should be prepared to post a link on their own company's public-facing website to ensure the file is publicly available, rather than on an internal site or benefits portal where it is available solely to the employees or plan participants. There is not any formal guidance on how or where exactly the link should be displayed on the website. The link does not need to be posted on the organization's main webpages, but we do not recommend intentionally making it hard to find either. Some administrators use multiple networks with differing provider agreements, so employers will need to link to the files applicable to the plans they sponsor. Employers may also need to link to multiple files if the vendors create separate data files for in-network providers vs. allowed amounts for out-of-networks claims.
- **Plans Without a Website:** CMS released a Technical Clarification that specifies that a group health plan that does not have its own website may satisfy this requirement by entering into a written agreement under which a service provider, such as a Third-Party Administrator, may post the link on its public website on behalf of the plan. The group health plan is a separate entity from the employer that sponsors the plan, so while this guidance does not clearly alleviate employers from needing to post the link to their public website at this point, it is a good indication that future guidance may go that way. CMS ended the Technical Clarification with a promise of forthcoming formal guidance.

NOTE: We are hopeful that there may be additional guidance coming from the agencies that would allow an administrator to satisfy the posting requirements on behalf of the health plans they administer, in which case employers offering self-insured coverage would not have to post anything on their company websites.

Section 4 - Prescription Drug Cost Reporting

Updated August 2022

Background

The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), the Treasury Department (IRS), and the Department of Labor (DOL) ["the agencies"] have released an interim final rule (IFC) addressing drug cost reporting requirements contained in the Consolidated Appropriations Act of 2021 (CAA). Health plans, including grandfathered plans, and health insurance carriers will be required to submit certain information about prescription drug and health care spending to the agencies annually. The agencies plan to use this information to issue public reports on prescription drug pricing costs and trends beginning in 2023. CMS calls the reporting requirement the "RxDC Report" ("Rx" stands for "Prescription Drug" and the "DC" stands for "Data Collection").

Plans and carriers must annually submit certain information on prescription drug and other health care spending, including:

- General information regarding the plan or coverage;
- Enrollment and premium information, including premiums paid by employees versus employers;
- Total health care spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs; and other medical costs), including prescription drug spending by enrollees versus employers and carriers;
- The 50 most frequently dispensed brand prescription drugs;
- The 50 costliest prescription drugs by total annual spending;
- The 50 prescription drugs with the greatest increase in plan expenditures from the previous year;
- Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or carrier in each therapeutic class of drugs, as well as for the 25 drugs that yielded the highest amount of rebates; and
- The impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs.

Most employer-sponsored health plans will need to rely heavily on their vendors such as their Third-Party Administrator (TPA) and/or Pharmacy Benefit Manager (PBM) to provide the data necessary, or to submit the plan's data to CMS. Any organization submitting data to CMS is referred to as a "reporting entity." There may be multiple reporting entities involved in compiling and submitting data for any particular employer plan.

In June of 2022, CMS published updated reporting instructions, including templates for the various data files that are required to be submitted. The IFC and the CMS instructions encourage reporting entities to submit aggregated data to CMS on behalf of all of their employer plan clients. However, at the time of the publication of this update, various vendors are taking different approaches. Some are planning to report aggregated data directly to CMS, while others are planning to provide the necessary data to the employer/plan sponsor with the expectation that the plan sponsor will submit their own data to CMS.

Detailed reporting instructions and other important information can be found on the CMS RxDC website at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

Effective Date

The CAA requires plans and carriers to submit the required information for the first time by December 27, 2021, and then by June 1 of each year thereafter. However, the agencies have delayed enforcement as long as the required information for 2020 and 2021 is submitted by December 27, 2022.

Compliance Responsibility

Employers with fully-insured group health plans, where all prescription drug coverage is provided through the group health plan, can rely on their carrier to submit the necessary data to CMS. However, if a fully-insured employer covers some prescription drug costs through separate arrangements, such as a specialty drug carve-out or a separate mail order drug benefit, other reporting may be necessary.

For employers who sponsor self-insured plans, CMS recognizes that employers will need to rely on their vendors to provide the required data to the employer for submission to CMS, or to submit the data on behalf of the employer's plan. However, CMS also makes it very clear that it is the employer/plan sponsor's responsibility to work with their vendors to ensure reporting is completed. CMS also recognizes that it is possible that no single entity will have all the information necessary, so some coordination will need to occur between stakeholders, such as the plan sponsor and their vendors.

The Reporting Process

Filles to be Submitted to CMS

Data is provided to CMS by submission of a series of files. There are 9 separate files, plus a narrative file, that are required for employer-sponsored group health plans.

Plan Lists

There is one plan list file applicable to employer-sponsored plans (Note - there are other plan lists for student health plans and the Federal Employee Health Benefit Plan):

P2. Group health plan list

Data Files

There are 8 separate data files that need to be submitted for employer-sponsored group health plans:

D1. Premium and Life-Years

D2. Spending by Category

- Hospital
- Primary care
- Specialty care
- Other medical costs and services
- Medical benefit drugs: known amounts
- Medical benefit drugs: estimated amounts

D3. Top 50 Most Frequent Brand Drugs

D4. Top 50 Most Costly Drugs

D5. Top 50 Drugs by Spending Increase

D6. Rx Totals

D7. Rx Rebates by Therapeutic Class

D8. Rx Rebates for the Top 25 Drugs

The Narrative File

Every submission should include a narrative response file to address a number of topics. Most of the topics included in the narrative response will need to be addressed by the carrier, PBM, or TPA. They include:

- Net payments from federal or state reinsurance or cost-sharing reduction programs
- Drugs missing from the CMS crosswalk
- Medical benefit drugs
- Prescription drug rebate descriptions
- Allocation methods for prescription drug rebates
- Impact of prescription drug rebates
- Employer size for self-insured plans (Employer would need to submit this only if they are filing files themselves.

Using The CMS Health Insurance Oversight System (HIOS).

Data is submitted through the RxDC module in the Health Insurance Oversight System (HIOS). HIOS is an application within the CMS Enterprise Portal at https://portal.cms.gov/portal/. Employers do not need to set up an account in HIOS if their vendors will be submitting all the required data on their behalf. However, depending on how the employer's vendors approach the requirement, some employers may need to submit at least some of the files themselves and therefore set up an account.

For employers who need to submit their own data, instructions for creating a CMS Enterprise Portal and HIOS account can be found at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-Portal-User-Manual.pdf.

The instructions for using the RxDC module are in the RxDC HIOS User Manual at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

CMS has also set up a help desk to assist with this process which can be reached at 1-855-267-1515 or CMS_FEPS@cms.hhs.gov.

Who Has the Data? – Who Will Submit it?

One of the most difficult things about the reporting process is that for many employers, no single entity will have all of the required data. As mentioned above, if an employer uses a single vendor such as a fully-insured health insurance carrier to process all the plan's prescription drug claims, that vendor is likely to have virtually all of the information needed to submit on behalf of the employer's plan. Other employers, however, will find that the required data may be held by different entities. Chart A identifies which organization is most likely to have the data necessary to submit each particular file.

Chart A

Data File	Who Has the Data?
P2. Group health plan list	Employer/TPA/PBM
D1. Premium and Life-Years	Employer/TPA
D2. Spending by Category	TPA
D3. Top 50 Most Frequent Brand Drugs	PBM
D4. Top 50 Most Costly Drugs	

D5. Top 50 Drugs by Spending Increase	
D6. Rx Totals	
D7. Rx Rebates by Therapeutic Class	
D8. Rx Rebates for the Top 25 Drugs	

Here is a link to a data collection spreadsheet our partners at BenefitComply created to assist employers with collecting information from their vendors. The spreadsheet shows exactly which data elements are required for each file.

Download Data Collection Spreadsheet here:
https://benefitcomply.com/wp-content/uploads/2022/08/Rx-Data-File-Responsibility.xlsx

The most common scenario will likely be that an employer will use their TPA to submit files D1 and D2 and separately work with a PBM to submit files D3 – D8. The process may become more complicated for employers when their vendors take different approaches to reporting.

For example, the instructions include "aggregation restrictions." If an employer or vendor chooses to submit the D2 "Spending by Category" file on a plan-specific basis, then the rest of the employer plan's D files must also be reported on a plan-specific, not aggregated, basis. This will be a problem if the employer or the employer's TPA wants to submit D2 on a plan basis, but the PBM plans to submit their data on an aggregate basis. If, on the other hand, the data submitted in D2 is aggregated (that is, not reported at the plan level), then the reporting entities for the other data files can choose whether they want to report information at the plan level or at the aggregate level.

We are also aware that there are employee benefit consultants and other consulting organizations that will provide services to assist the employer in working with their vendors and coordinating the employer plan's data submission.

Administrative Issues and Outstanding Questions

Unfortunately, the CMS instructions do not clearly address several administrative issues that may present challenges to employers working with multiple vendors. We have compiled a list of issues and outstanding questions. We will regularly update this information as additional guidance is issued and vendors make progress implementing their various reporting strategies:

- Some vendors have communicated that they plan to submit aggregated data for all of their clients and will not provide plan-specific data to the employer. Other vendors are planning to simply provide the data to the employer and assume the employer will take responsibility for the submission to CMS. Without a uniform industry process, it may be difficult for employers with multiple vendors to ensure that their plan data is correctly submitted.
- Employers who have a relatively complex set of vendors who cover or administer Rx related payments (e.g., PBM carve-out, separate specialty drug benefit, stand-alone mail order Rx benefit, etc. will struggle to coordinate with the various vendors to determine if all of the plan's Rx costs have been reported.
- Early communications from a number of large PBMs indicate that for the PBM to complete file D6, the employer or TPA may need to provide some plan cost data not typically housed by the PBM.
- CMS instructions state that multiple reporting entities should not submit the *same* data file for a plan. For example, a TPA and PBM should not both submit D2 for the same group health plan. However, if an employer works with different vendors, there is no requirement that those vendors coordinate their submissions, and unrelated vendors may not agree to coordinate filings.

Summary and Employer Next Steps

Employers and vendors face many challenges to complete the required Rx reporting, and CMS understands that the data will not be perfect, especially the first time it is submitted. Vendors will also likely coalesce around more common processes as the industry gains experience with the CMS reporting system and additional guidance is issued. At this point, employers should be actively working with their vendors to determine how much of the reporting will be done by the vendor, and what, if anything, the employer will need to do to complete the process. We anticipate that as long as an employer is making a good faith attempt to comply, the regulatory agencies will be trying to assist employers and vendors in completing the reporting rather than taking enforcement actions, at least for the first couple of years of the requirement.

Section 5 – Pricing Tools

Background

The next phase of the Transparency Requirements will be the requirements for carriers and plans to develop an Internet-based price comparison tool. The tool will allow an individual to receive an estimate of their cost-sharing responsibility for a specific item or service from a specific provider or providers. The information must also be made available by phone or on paper upon request from participant.

Many carriers already offer some kind of online health cost estimator. However, most existing tools will need significant modifications to meet the new price comparison requirements.

Effective Date

This information must be available for plan years beginning on or after January 1, 2023, with respect to the 500 items and services identified by the agencies in Table 1 in the preamble to the TiC Final Rule, and with respect to all covered items and services for plan or policy years beginning on or after January 1, 2024.

Compliance Responsibility

As with many of the requirements described in this guide, employers will need to rely on their carriers and administrators to develop and implement these cost comparison tools.

Section 6 – Other Pending Requirements

Rx Cost Data Machine Readable File Delayed

After the agencies finalized the TiC Final Rule, Congress enacted the CAA, which imposes the new prescription drug reporting requirements described in Section 4 of this guide. The agencies recognized that there is significant overlap in what needs to be reported in the CAA reporting rule effective December 27, 2022, and what would be included in the prescription drug cost data machine-readable file. Consequently, the agencies have decided to delay enforcement of the TiC Final Rule's prescription drug cost data machine-readable file requirement until further guidance is issued.

Provider Good Faith Cost Estimates and Advanced EOBs

Background

The last initiative of the Transparency Requirements requires providers to provide a good faith estimate of the cost of medical services to a patient. Subsequently, the plan or carrier will be required to provide a participant with an "Advanced Explanation of Benefits (EOB)" estimating the participant's out-of-pocket cost for those services.

Details

The CAA requires providers and facilities to inquire whether the individual is enrolled in a health plan or health insurance coverage and to provide a good faith estimate of the expected charges. If the individual is enrolled in a health plan or other coverage, the provider must provide this notification to the individual's plan.

Upon receiving a "good faith estimate" from the provider, the plan or carrier must provide an Advanced EOB notification in clear and understandable language. The notification must include:

1. The network status of the provider or facility;
2. The contracted rate for the item or service, or if the provider or facility is not a participating provider or facility, a description of how the individual can obtain information on providers and facilities that are participating;
3. The good faith estimate received from the provider;
4. A good faith estimate of the amount the plan or coverage is responsible for paying, and the amount of any cost-sharing for which the individual would be responsible for paying with respect to the good faith estimate received from the provider; and
5. Disclaimers indicating whether coverage is subject to any medical management techniques.

The EOB also must indicate that the information provided is only an estimate based on the items and services reasonably expected to be provided at the time of scheduling (or requesting) the item or service and is subject to change.

Effective Date and Delayed Enforcement

These provisions were originally scheduled to go into effect for plan years beginning on or after January 1, 2022. However, the agencies received feedback from the industry about the challenges of developing the technical infrastructure necessary for medical providers to transmit the necessary information to plans and carriers. As a result, the agencies plan to issue additional guidance in the future to implement this provision, including establishing appropriate data transfer standards. Until that time, the agencies will delay enforcement of the requirement that plans and carriers must provide an Advanced EOB.

Appendix A – Additional Resources

Transparency in Coverage Final Rule - https://www.govinfo.gov/app/details/FR-2020-11-12/2020-24591

Prescription Drug Reporting Interim Final Rule (IFC) - https://www.federalregister.gov/documents/2021/11/23/2021-25183/prescription-drug-and-health-care-spending

CMS Machine-Readable Files FAQ - https://www.cms.gov/sites/default/files/2022-04/FAQ-Affordable-Care-Act-Implementation-Part-53.pdf

CMS Transparency in Coverage Website - https://www.cms.gov/healthplan-price-transparency