Transparency in Coverage and CAA Provisions Status Update

In October 2020, the Department of Health and Human Services (HHS), Department of Labor (DOL) and Department of Labor released the Transparency in Coverage (TiC) Final Rules, including several provisions applicable to most group health plans and insurance carriers. A few weeks later, in December 2020, the Consolidated Appropriations Act of 2021 (the "CAA") was signed into law, including several provisions impacting group health plans and health insurance carriers. Importantly, the CAA provisions amended the Public Health Service Act (PHSA), the Internal Revenue Code (the Code), and ERISA, thereby applying to all group health plans, including grandfathered plans; private, church, and non-federal government plans; and fully insured and self-insured/level-funded plans.

Grandfathered plans should review their plans for compliance with the CAA.

Employers sponsoring self-insured/level-funded plans are responsible for satisfying the provisions. However, in many cases the employer must rely on other entities to comply. If the plan is fully insured, the insurance carrier will handle many of the obligations, althought the carrier may need additional information and/or acknowledgment from the employer.

We recommend employers secure written confirmation(s) delegating responsibility to their carrier, third-party administrator (TPA) and/or pharmacy benefit manager (PBM), where applicable.

The following provides a summary of those provisions, including updated guidance and the status of its implementation or effective date and enforcement.

TIC FINAL RULES FOR DISCLOSURES OF RATES, OUT-OF-NETWORK ALLOWED AMOUNTS, BILLED CHARGES AND NEGOTIATED RATES

Summary	Non-grandfathered plans must publicly disclose cost-sharing information in separate machine- readable files (MRFs), updated monthly.
Effective Date and Enforcement Date	MRFs must be updated every month, starting **June 2022**. Prescription drug file implementation delayed due to overlap under CAA Section 204. Additional regulatory guidance coming in 2024, which will require the third MRF regarding prescription drugs to be published.
Notes	These files are large and not readily accessible to the layperson. The first step in transparency is getting the information out in the open. In **September 2023**, CMS updated its FAQs on ACA implementation and said that it will begin enforcing the TiC Final Rules and exercise "enforcement discretion," effectively revoking the TiC enforcement safe harbor from prior years.
Action Items	**Fully Insured:** Employers should enter into a written agreement (contract) with the carrier, obligating the carrier to provide and maintain the MRFs. If the carrier requires the employer to post the MRF to a website owned by the employer, the employer should do so. **Self-Insured:** Employers should enter into a written agreement (contract) with the TPA or other parties to provide and maintain the MRFs. Contract may include indemnification to the employer, should the contracted party fail to perform. Plans seeking indemnification must provide on their own website a public-facing link where data may be retrieved.

REPORTING PHARMACY BENEFIT AND DRUG COSTS — CAA SECTION 204

Summary	Requires group health plans and health insurance carriers to report information to CMS regarding the cost of prescription drugs. The annual pharmacy data collection (RxDC) is extensive and includes: the 50 most-dispensed brand drugs, number of paid claims for each of the 50 most-dispensed brand drugs, the 50 costliest drugs in terms of annual spend and the 50 drugs with the greatest increase in cost.
Effective Date and Enforcement Date	The first report collecting data on calendar years 2020 and 2021 was due on **December 27, 2022**. Each subsequent annual report is due by **June 1** for the collection of data on the prior calendar year.
Notes	The agencies are particularly interested in the impact of premium rebates and other consideration paid by drug manufacturers. The narrative responses answer this and other questions that may require the employer to provide information for complete filing purposes. This provision is largely duplicative of the TiC Final Rules pharmacy MRF reporting — hence the parallel TiC requirements being on an indefinite delay.
Action Items	**Fully Insured:** Employers should confirm their carrier is handling reporting on their behalf. **Self-Insured Plans:** Employers should confirm responsibilities and consider including this provision in future requests for services. Any employer whose carrier or TPA is not filing on their behalf, or whose carrier or TPA is asking the employer complete certain sections of the filing: Review the CMS instruction manual and complete the reporting by the deadline.

ACCESS AND MAINTENANCE OF PRICE COMPARISON TOOL FOR PERSONALIZED COST-SHARING INFORMATION — TIC FINAL RULES AND CAA SECTION 114

Summary	All plans and issuers must make an internet-based self-service price comparison tool that allows an individual enrolled under such plan or coverage — with respect to such plan year, geographic region and participating providers — to compare the individual's cost-sharing amount. Comparison guidance must be available by telephone.
Effective Date and Enforcement Date	**January 1, 2023:** Specific to 500 items outlined in the TiC Final Rules. **January 1, 2024:** Specific to all items outlined in the TiC Final Rules.
Notes	This is an area of overlap between the TiC Final Rules and the CAA. The CAA deadline is extended to align with the TiC Final Rules.
Action Items	Evaluate contracts with carriers and providers to confirm responsibility and availability of a price comparison tool.

PREVENTING SURPRISE MEDICAL AND AIR AMBULANCE BILLS — CAA SECTION 102

Summary	The intent is to prevent surprise billing (or "balance billing") in situations unavoidable by participants. Participants pay the in-network cost-sharing amount for: (1) emergency care received at out-of-network (OON) facilities; (2) certain ancillary services provided by OON providers at in-network facilities; and (3) OON care provided at in-network facilities without the participant's informed consent. Providers and plans have negotiation and dispute-resolution processes.
Effective Date and Enforcement Date	Effective for plan years beginning on or after **January 1, 2022**.
Notes	Applies to all individual and group health plans, including **grandfathered** and **self-insured/ level-funded** plans. **Note:** Grandfathered plans must provide external review of adverse benefit determinations for claims subject to these protections.
Action Items	Revise plan documents and SPDs where applicable. Ensure that in-network cost-sharing payments for OON surprise bills apply to the in-network deductible. Include the Surprise Billing Notice in onboarding and/or Open Enrollment materials. Consider whether adding an air ambulance and/or ground ambulance point solution or rider would be advantageous based on existing plan designs and employee populations.

BALANCE BILLING DISCLOSURE REQUIREMENTS — CAA SECTIONS 104 AND 105

Summary	Plans must provide participants with a Balance Billing Disclosure notifying them of the prohibition on surprise billing and providing contact information in the event the rules are violated.
Effective Date and Enforcement Date	Effective for services rendered on or after **January 1, 2022**.
Notes	Applies to all individual and group health plans, including **grandfathered** and **self-insured/ level-funded** plans.
Action Items	Include the Surprise Billing Notice in the annual notice packet.

INSURANCE ID CARDS — CAA SECTION 107

Summary	Requires plans and carriers to include on any physical or electronic plan or insurance identification card issued to participants, beneficiaries, or enrollees any applicable deductibles, out-of-pocket maximum limitations and a telephone number and website address for consumers seeking consumer assistance. The information must be provided in clear writing.
Effective Date and Enforcement Date	Effective for plan years beginning on and after **January 1, 2022**. Plans and issuers must use a reasonable, good-faith effort to comply.
Notes	
Action Items	Plans and carriers must determine how to represent plan and coverage designs in a compliant way.

CHOICE OF HEALTHCARE PROFESSIONAL AND DIRECT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE — CAA SECTION 102

Summary	Plans that require participants to designate a primary care provider (PCP) must permit any willing in-network PCP, pediatrician for children or OBGYN for women for that purpose.
Effective Date and Enforcement Date	Effective for plan years beginning on or after **January 1, 2022**.
Notes	Plans may not require prior authorization or referral for affected participants. **Note:** Grandfathered plans are required to allow choice of healthcare professionals and direct access to obstetrical and gynecological care.
Action Items	Review and revise plan documents and SPDs. Include the Patient Protection Notice in the SPD and annual notice packets.

ADVANCED EXPLANATION OF BENEFITS (AEOB) — CAA SECTION 111

Summary	Plans must provide (via mail or electronically) a participant, beneficiary or enrollee an AEOB in clear and understandable language that includes: (1) the network status of the provider or facility; (2) the contracted rate (for participating providers or facilities) or a description of how a participant can obtain information about participating providers or facilities; (3) good-faith estimate received from the provider or facility; (4) a good-faith estimate of the participant's cost-sharing and the plan's responsibility for paying for the items or services; and (5) information regarding any medical management techniques that apply to the items or services.
Effective Date and Enforcement Date	Effective for plan years beginning on or after January 1, 2022. **Enforcement delayed pending further guidance from the DOL.**
Notes	The DOL intends to engage in notice-and-comment rulemaking in the future to implement these requirements, including establishing appropriate data-transfer standards. Accordingly, the DOL will defer enforcement until the regulations are finalized.
Action Items	Monitor compliance notifications from your carrier, TPA and broker to understand the requirements once the Department of Labor issues additional guidance.

CONTINUITY OF CARE — CAA SECTION 113

Summary	Requires plans and carriers to ensure that certain participants, referred to as "continuing care patients," are not harmed when a provider ceases to be in-network. Continuing care patients include those who are: • Undergoing a course of treatment for a serious and complex condition; • Undergoing a course of institutional or inpatient care; • Scheduled to undergo nonelective surgery, including postoperative care with respect to such surgery; • Pregnant and undergoing a course of treatment for the pregnancy; • Determined to be terminally ill.
Effective Date and Enforcement Date	Effective for plan years beginning on or after **January 1, 2022**. Plans and issuers must use a reasonable, good-faith effort to comply.
Notes	Plans and issuers must use a reasonable, good-faith effort to comply.
Action Items	Plans or issuers must notify each "continuing care patient" with respect to a provider or facility at the time of a termination of the individual's right to elect continued transitional care from provider or facility; provide individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and permit the patient to elect to continue to have benefits provided under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient up to 90 days.

PROVIDER DIRECTORIES — CAA SECTION 116

Summary	Plans or issuers must establish a process for updating and verifying the accuracy of information in their provider directories and establish a protocol for responding to telephone calls and electronic communications from participants, beneficiaries or enrollees about a provider's network participation status.
Effective Date and Enforcement Date	Effective for plan years beginning on or after **January 1, 2022**.
Notes	Plans and issuers must honor any incorrect or inaccurate information provided to the participant, beneficiary or enrollee about the provider's network participation status. Cost-sharing amounts must count toward any deductible or out-of-pocket maximum.
Action Items	Plans and carriers must comply with these requirements and will not be considered to be out of compliance if a participant receives items and services from a nonparticipating provider and the individual was provided inaccurate information indicating the provider was participating and only a cost-sharing amount that was equal to or less than the in-network amount.

BROKER COMPENSATION DISCLOSURE — CAA SECTION 202

Summary	Amends Section 408(b)(2) of ERISA and creates new transparency requirements that impact group health plans and their brokers or consultants. Specifically, group health plans must receive disclosures from brokers or consultants (or their affiliates or subcontractors) who reasonably expect to receive $1,000 or more (indexed for inflation) in direct or indirect compensation in connection with providing certain designated insurance-related services for the group health plan. The disclosures include description of the services, a description of direct compensation and a description of indirect compensation, including finder's fees.
Effective Date and Enforcement Date	**For contracts executed before December 27, 2021: the date the contract renews or is extended.** **For contracts executed after December 27, 2021: effective immediately.**
Notes	Applies to all group health plans, regardless of funding or size. Applies to all excepted benefits (dental and vision plans). Applies to all covered service providers.
Action Items	Brokers, TPAs, and service providers should assist employers in satisfying this requirement by proactively providing the compensation disclosures form.

MENTAL HEALTH PARITY — CAA SECTION 203

Summary	Requires health plans to perform and document comparative analyses of the design and application of nonquantitative treatment limitations (NQTLs) to be provided upon request to federal regulators and plan participants.
Effective Date and Enforcement Date	**Effective February 10, 2021.**
Notes	A report found the top noncompliance areas included: limitations or exclusions of applied behavior analysis (ABA) therapy or other services to treat Autism; nutritional counseling and medication-assisted treatment (MAT) for opioid use disorder; restrictive billing requirements; and varying preauthorization or precertification requirements.
Action Items	Employers sponsoring self-insured or level-funded health plans should have a process in place to complete the analyses or request the analyses from their TPA. Consider including language in the ASO agreement to delineate responsibilities between an employer and third-party administrator for self-funded plans. Based upon the analysis, amend plan designs to remove plan choices that create disparities, such as requiring preauthorization only for inpatient services related to mental health claims.

PROHIBITION ON GAG CLAUSES — CAA SECTION 201

Summary	Plans may not enter contracts that include gag clauses and must remove gag clauses in current contracts between providers and plans that prevent enrollees, sponsors and referring providers from seeing cost and quality data on providers. Providers, networks or associations of providers, TPAs and other service providers are prohibited from either directly or indirectly restricting (by agreement) plans or carriers from providing provider-specific cost or quality-of-care information or data to referring providers, the plan sponsor, participants, beneficiaries, enrollees, or individuals eligible to become participants, beneficiaries or enrollees of the plan or coverage.
Effective Date and Enforcement Date	Effective for plan years beginning on or after January 1, 2022. **The first attestation is due December 31, 2023, and subsequent attestation covering the period since the prior attestation are due December 31 of each year.**
Notes	The CAA requires group health plans and health insurance carriers to attest annually to the government that they have no gag clauses in their contracts. Plans and carriers must complete the GCPCA form electronically, using the form provided by federal regulatory agencies.
Action Items	Plans and carriers are required to submit an annual report (attestation) to the DOL, HHS or IRS confirming compliance with these requirements.