# TRANSPARENCY AND NO SURPRISES ACT OBLIGATIONS OF GROUP HEALTH PLANS

*This white paper attempts to provide a high-level overview of important compliance requirements and effective dates under the recent federal legislation.*

## GENERAL BACKGROUND

Recent federal legislation has imposed significant new compliance obligations upon group health plan sponsors. These laws are designed to achieve several important objectives. One goal is to enable participants to better evaluate healthcare options and make cost-conscious decisions. Another purpose is to reduce the potential for participants to receive unexpected bills for healthcare services. Over the long-term, the laws are intended to create a more competitive healthcare marketplace that puts downward pressure on prices and thus lowers overall healthcare costs.

To achieve these objectives, the DOL, IRS and HHS first issued the Transparency in Coverage (TiC) final rule[1] in October 2020. This rule requires non-grandfathered group health plans to disclose certain data, such as in-network (INN) provider negotiated rates and historical out-of-network (OON) allowed amounts to the public via machine-readable files posted to a website. Additionally, these plans must provide participants with personalized cost-sharing information for covered services via an online self-service tool. The rule has phased-in effective dates from 2022 to 2024.

Subsequently, Congress passed the Consolidated Appropriations Act, 2021 (CAA)[2] in December 2020. This stimulus relief measure incorporates patient protections and a variety of additional transparency and disclosure obligations applicable to group health plans (including grandfathered plans). Amongst other provisions, the CAA No Surprises Act (NSA) includes comprehensive surprise billing prohibitions. In early July 2021, an interim final rule was issued that provides guidance regarding the implementation of aspects of the NSA surprise billing provisions.

On August 20, 2021, the DOL, IRS and HHS released FAQs[3] regarding the implementation of other CAA provisions. This guidance provides temporary enforcement relief with respect to specific CAA provisions pending the issuance of regulatory guidance. Additionally, certain deadlines for CAA requirements have been adjusted to better align and coordinate with similar requirements under the TIC final rule.

However, group health plan sponsors should not delay in consulting with their carriers or administrative service providers regarding implementing these new requirements. Although plan sponsors are ultimately responsible for compliance, it is anticipated that most will rely heavily upon third-party administrators to timely satisfy these obligations. So, sponsors should keep these new mandates in mind when negotiating service agreements and vendor contracts for upcoming plan years. They should also budget for the additional costs of compliance. Of course, employers should engage counsel for legal advice regarding the specific application of these laws to their group health plans and/or for assistance with related vendor contract negotiations.

This white paper, presented in chart format, attempts to provide a high-level overview of important compliance requirements and effective dates under the recent federal legislation. References are provided for regulatory guidance issued as of the publication date; additional implementing guidance is expected. Compliance considerations and action items for group health plans sponsors are also included.

1 DOL, HHS and IRS. "Transparency in Coverage," Federal Register, govinfo.gov, 2020; **https://www.govinfo.gov/content/pkg/FR-2020-11-12/pdf/2020-24591.pdf**.

2 US Congress. Consolidated Appropriations Act, rules.house.gov, 2021; **https://rules.house.gov/sites/democrats.rules.house.gov/files/BILLS-116HR133SA-RCP-116-68.pdf**.

3 DOL, HHS and IRS. "FAQs About Affordable Care Act and Consolidated Appropriations Act," dol.gov, 2021; **https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf**.

## TRANSPARENCY IN COVERAGE (TIC) FINAL RULE

| Specific Requirement | Stated Purpose | Applicability | Effective Date and Regulatory Guidance | Employer Action Required |
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| **Public Disclosure of Pricing Data**<br>Plans must disclose:<br>1. Negotiated rates for INN covered items and services.<br>2. Historical OON billed charges and payment amounts for a recent 90-day period.<br>3. Prescription drug negotiated rates and historical net prices.*<br>Required format is machine-readable files that must be updated monthly.<br>Disclosures must be provided free of charge and without requiring the establishment of a user account or password to access. | Creation of a more competitive pricing environment by narrowing price dispersions for the same items and services in the same healthcare markets.<br>Long-term goal is to lower overall healthcare costs by putting downward pressure on prices. | Applies to insured and self-insured non-grandfathered group health plans.<br>Does not apply to account- based plans such as HRAs and FSAs, excepted benefits or expatriate health plans.<br>Limited exception with respect to historical out-of-network disclosures may apply to small plans (for privacy protection reasons). | Original enforcement date:<br>Plan years beginning on or after January 1, 2022.<br>Final rule issued in 2020:<br>**2020-24591.pdf (govinfo.gov)**<br>DOL CAA FAQs issued August 20, 2021, deferred enforcement date to July 1, 2022, for INN files and OON billed charges.<br>*Prescription drug file requirement postponed until regulators determine if it is still appropriate given similar CAA pharmacy benefit reporting requirement. (FAQ #1)<br>**FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (dol.gov)** | 1. Consult with carrier or service provider regarding implementation.<br>2. Ensure new, renewed, or extended contracts address these requirements.<br>Insured plans can contract with carrier to assume liability for disclosures.<br>Self-insured plans can contract w/ vendor but remain liable for disclosures.<br>3. Budget for implementation costs.<br>4. Prospectively, use publicly disclosed data as a comparison tool for plan prices and contract negotiations. |
| **Participant Cost-Sharing Tool**<br>Plans must disclose the following cost-sharing information at the request of a participant:<br>1. Estimate of cost-sharing liability for the covered item or service.<br>2. Accumulated amounts incurred to date.<br>3. INN rate (as a dollar amount) for an INN provider (includes negotiated rate and fee schedule).<br>4. OON allowed amount for item or service (if the provider is OON).<br>5. If a bundled payment arrangement, a list of the items or services.<br>6. Any prerequisites for the item or service.<br>Required format is an internet-based self-service tool (or paper upon request). *<br>A disclosure notice with certain information (e.g., estimate is not a guarantee) must be provided. | Enable participants to better evaluate healthcare options and to make cost-conscious decisions.<br>Reduce potential surprises in relation to participant out-of-pocket costs for healthcare services. | Applies to non-grandfathered group health plans and insurers.<br>Does not apply to account-based plans, such as HRAs and FSAs, excepted benefits or expatriate health plans. | Cost-sharing tool must be available:<br>- For 500 items and services specified in the final rule for plan years beginning on or after January 1, 2023.<br>- For all items and services for plan years beginning on or after January 1, 2024.<br>Final rule issued in 2020:<br>**2020-24591.pdf (govinfo.gov)**<br>*The regulators intend to propose rules as to whether compliance with the TiC Cost-Sharing Tool requirement, with the addition of fulfilling participant requests made by phone, would also satisfy the CAA Price Comparison Tool requirement. (FAQ #3)<br>**FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (dol.gov)** | Please see comments 1-3 above.<br>Additionally, for the cost-sharing tool, the employer will need to develop instructional material for participants to use the tool effectively to compare healthcare costs. |

## CONSOLIDATED APPROPRIATIONS ACT, 2021 (CAA)

| Specific Requirement | Stated Purpose | Applicability | Effective Date and Regulatory Guidance | Employer Action Required |
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| **Removal of Gag Clauses**<br>• Plans cannot agree to provider or TPA contract provisions that would directly or indirectly restrict them from accessing provider-specific cost and quality of care information and providing the information to participants or referring providers.<br>• Plans must also have electronic access to de-identified participant claims data that reflect the costs related to claims.<br>• Contracts may include reasonable restrictions on public disclosure of data.<br>• Plans must submit an annual attestation to certify compliance with the requirement. | To ensure group health plans have access to certain cost and quality of care information. | Group health plans (including grandfathered plans). | December 27, 2020 (enactment date of the CAA).<br>Section 201 of the CAA.<br>DOL FAQ #7 issued August 20, 2021, confirms December 27, 2020, effective date. Guidance to be issued on required attestation (to be collected beginning in 2022).<br>**FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (dol.gov)** | 1. Review contracts with insurers, administrative service providers and third-party administrators offering access to provider networks to ensure compliance with this requirement.<br>2. Existing contracts that contain prohibited restrictions will require amendment.<br>3. Consult with counsel for assistance with contract review and amendments.<br>4. Be prepared to submit annual certification of compliance (once guidance is provided on the certification process). |
| **Mental Health Parity and Addiction Act (MHPAEA) Nonquantitative Treatment Limitation (NQTL) Comparative Analysis**<br>• Plans must perform and document a detailed analysis of the design and application of each NQTL imposed by the plan, including specific findings and conclusions regarding MHPAEA compliance.<br>• Background: NQTLS are limitations not tied to specific monetary or visit limits. Examples are utilization review requirements, experimental treatment exclusions, step therapy protocols and standards for provider admissions to a network.<br>• MHPAEA requires that under both the plan terms and in operation, any processes, strategies, evidentiary standards or other factors used in applying NQTLS to mental health and substance use disorder (MHSUD) benefits in a class cannot be more restrictive than those applied to medical or surgical benefits.<br>• Analysis must be provided to the DOL, HHS or state regulatory agency upon request. If deemed insufficient. Plan will have a 45-day corrective period to demonstrate compliance. | Written analysis requirement is a formalization of the existing NQTL compliance requirements. | Plans that offer MHSUD and medical and surgical benefits and impose NQTLs on the MHSUD benefits.<br>Exceptions are retiree-only group health plans, self-insured governmental plans electing exemption, small employers with 50 or less employees, plans offering excepted benefits only. | February 10, 2021<br>Section 203 of the CAA.<br>DOL issued FAQs on MHPAEA Implementation and the CAA.<br>**FAQs-Part-45 (dol.gov)**<br>Per guidance, NQTL enforcement priorities include prior authorization requirements, concurrent review, standards for provider admission to a network, and OON reimbursement rates.<br>Please see our summary of the FAQs: **https://www.nfp.com/About-NFP/Insights/Compliance-Corner/Federal-Updates/dol-issues-faqs-regarding-mental-health-and-substance-use-disorder-parity-caa-implementation**<br>Additional implementation guidance is expected by June 2022. | 1. Contact carrier or administrative services provider to request a copy of the analysis or if one can be performed. Insurers are also subject to these requirements, so an analysis may be available for fully insured plans. Self-insured plans would need to consult with the service provider to see if one can be prepared.<br>2. Prospectively, ensure that new and renewed contracts address the analysis and that carrier or TPA will provide.<br>3. Review DOL MHPAEA Self-Compliance Tool, which outlines 5 step NQTL analysis.<br>**Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (dol.gov)**<br>4. Ensure final written analysis provides detailed and reasoned explanation for compliance for each NQTL. Be prepared to provide analysis and supporting data (plan documents, claims data, internal analysis) to regulators upon request.<br>5. Establish a procedure for ongoing compliance and participant requests for the comparative analysis. |

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| **Pharmacy Benefit and Prescription Drug Cost Reporting**<br>• Plans must report certain information on prescription drug costs and spending to the DOL, HHS, and Treasury, including:<br>• General plan information (e.g., plan year; participant count and states where coverage is offered)<br>• The plan's 50 most dispensed brand prescription drugs and total paid claims for each;<br>• The plan's 50 most costly drugs by total annual spending and annual amount spent for each;<br>• The 50 drugs with the greatest annual cost increase and change in amount of each;<br>• Total spending by the plan (broken down by types of service, such as hospital and primary care);<br>• Drug spending by plan and participants and monthly premiums paid by employer and employee;<br>• Impact of rebates and fees paid by drug manufacturers on premiums. | The regulatory agencies will compile this information in a publicly available biannual report on prescription drug reimbursement, pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases.<br>Goal of reporting is to achieve national health data transparency and lower drug costs. | Group health plans (including grandfathered plans) that provide pharmacy benefits and prescription drugs. | December 27, 2021 (first report).<br>By June 1 annually (subsequent reports).<br>Section 204 of the CAA<br>Request for Information issued June 23, 2021 **2021-13138.pdf (govinfo.gov)**<br>DOL FAQs issued August 20, 2021, delay enforcement pending issuance of regulations or further guidance. Plans are strongly encouraged to be prepared to report 2020 and 2021 data by December 27, 2022. (FAQ #12)<br>**FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (dol.gov)** | 1. Consult with prescription drug carrier (for insured plans) or pharmacy benefit service provider regarding compliance with these requirements, including the collection of the necessary data and related costs.<br>2. If carrier or TPA agrees to assist with reporting, obtain written confirmation and amend service contracts to reflect each party's obligations.<br>3. Monitor regulatory updates for specific reporting requirements.<br>4. Prospectively, review the biannual compilations released by the regulators, which can serve as a benchmark for future prescription drug spending and negotiations. |
| **Service Provider Compensation Disclosure**<br>• Prior to a contract or renewal date, plan service providers must provide written disclosure to the plan fiduciary of any compensation (direct or indirect) they will receive for services provided on behalf of the plan.<br>• Applies if provider receives $1,000 or more in compensation.<br>• Disclosure requires a statement of services (including, if applicable, fiduciary services) and all expected compensation (whether transaction-based, an incentive, etc.).<br>• Notice must be provided of changes to the fees or services (generally within 60 days). | ERISA Section 408(b)(2) requires that compensation paid to service providers be reasonable and for necessary services.<br>Disclosure is intended to provide employer with sufficient information to make this determination and identify potential conflicts of interest.<br>Retirement plans have been subject to similar requirement since 2012. | Group health plans, including grandfathered plans and account-based plans such as FSAs and HRAs. | December 27, 2021<br>Upon the effective date, disclosure is required before a contract is entered, extended, or renewed.<br>(Contracts entered before December 27, 2021, appear to be exempt, unless renewed or extended.) | 1. Review existing service provider contracts to determine the renewal or extension date.<br>2. Request compensation disclosure if not provided before entering, extending or renewing a service provider contract on or after December 27, 2021.<br>3. Review disclosure for accuracy and reasonableness and if necessary, send written request to provider for clarification.<br>4. Retain copy of disclosure for fiduciary records. Establish a procedure for ongoing compliance. |

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| **Surprise Billing and Independent Dispute Resolution (IDR)**<br>• If a plan covers benefits for emergency services, coverage must be provided: without prior authorization, regardless of whether provider/facility is INN and regardless of other plan terms/ conditions (other than exclusions, COBs, waiting periods).<br>• Cost-sharing for OON services subject to the protections are limited to that for INN levels and must count toward INN deductibles and out-of-pocket (OOP) maximums.<br>Limits apply to OON emergency and air ambulance services and certain post-stabilization and non-emergency services by OON providers (e.g., anesthesiologist at in-network facilities).<br>• Balance billing is prohibited.<br>• Cost-sharing for OON services is based on (in order): (1) All-Payer Model Agreement; (2) State law or (3) Lesser of billed charge or plan's median contracted rate for service in the geographic region.<br>• Payment to OON provider is based on (in order): (1) All-Payer Model Agreement; (2) State law; (3) Agreed upon amount or (4) Amount determined by IDR.<br>• Health plans must disclose certain information to OON providers with initial payment or denial, including contracted rate, contact to open negotiation period and process to initiate IDR.<br>• In very limited situations and upon notice, consent can be obtained from a participant for OON care and extra costs. | Eliminate balance billing and resulting financial consequences to participants in situations in which they cannot choose a provider or ensure all their care is from an INN provider.<br>Reduce possibility of providers using surprise billing as leverage to get higher payments, which results in higher premiums and healthcare costs overall.<br>Fill in gaps left by state laws, which typically do not cover self-insured plans sponsored by private employers (due to federal preemption) or surprise bills that involve out-of-state providers. | Group health plans (including grandfathered plans).<br>Does not apply to retiree-only plans, excepted benefits or HRAs. | Plan years beginning on or after January 1, 2022.<br>Provisions of the CAA NSA<br>Interim Final Rule (with comment period), "Requirements Related to Surprise Billing; Part I" issued July 2021.<br>Comment period ended September 7, 2021.<br>**https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf**<br>For our summary of the rule, please see: **https://www.nfp.com/About-NFP/Insights/Compliance-Corner/Federal-Updates/federal-agencies-issue-interim-final-rules-implementing-the-no-surprise-billing-act**<br>Further guidance expected soon, including regulations to address the IDR entities and process. | 1. Consult with carrier (for insured plans) or service provider to ensure they will be able to implement the new requirements by the effective date.<br>2. Review and amend carrier or service provider contracts to reflect responsibilities regarding surprise billing, disclosures, timely payments or denials, negotiations, and the IDR process.<br>3. Update plan documents and SPDs, as necessary, to incorporate the new rules.<br>4. Post required notice of surprise billing protections on website and include in each EOB. See DOL Model Notice at:<br>**https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act**<br>5. Monitor impact on plan costs.<br>6. Evaluate whether the stop-loss contract should be modified due to potential changes in costs and timeframes to finalize provider claims.<br>7. Monitor updates for additional information on IDR process and model balance billing disclosures. |

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| **Continuity of Care Provisions**<br>• Plans must provide notice to "continuing care patients" when a plan's contract with an INN provider is terminated.<br>• Applies to participants scheduled for non-elective surgery or receiving institutional or inpatient care or care for a serious and complex condition, a pregnancy or terminal illness from the provider.<br>• Notice must explain how to elect transitional coverage for up to 90 days at INN rates.<br>• Providers cannot balance bill the participant but must accept payments at INN rates as payments in full. | To protect participants undergoing care for certain conditions and serious illnesses from unanticipated INN provider terminations by the plan. | Group health plans (including grandfathered plans). | Plan years beginning on or after January 1, 2022.<br>Section 113 of CAA NSA<br>Per DOL FAQ #10 issued August 20, 2021, good faith compliance based upon a reasonable interpretation of the law applies pending issuance of guidance. (Guidance not expected until after effective date.)<br>**FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (dol.gov)** | 1. Consult with carrier or administrative service provider to ensure they are prepared to comply with this new requirement and provide the required disclosures, when applicable.<br>2. Amend carrier or service contracts as necessary to address the new requirements and related costs.<br>3. Update plan documents as appropriate. |
| **Provider Directories**<br>• Plan must maintain an accurate and current director of INN providers and facilities on a public website.<br>• Information in the database must be updated and verified at least every 90 days. Updates must be made within 2 days of notice by providers.<br>• Plans must respond within one business day to a participant request for information regarding whether a provider is INN and retain the communication in the participant's file for at least 2 years.<br>• If a database, directory or communication incorrectly reflects a provider is INN, the INN cost sharing applies, and payments are applied to the deductible and OOP limit. | Protect participants from unexpected medical costs due to outdated network provider directories. | Group health plans (including grandfathered plans). | Plan years beginning on or after January 1, 2022.<br>Section 116 of CAA NSA<br>DOL FAQ #8 issued August 20, 2021, confirms January 1, 2022, effective date with good faith compliance pending issuance of guidance. (Guidance not expected until after effective date.)<br>**FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (dol.gov)** | 1. Consult with carrier or administrative service provider to confirm they are prepared to comply with this provision and timely update databases and directories, and respond to participant requests, maintain necessary records, update EOB and website with required additional information.<br>2. Amend carrier or service contracts as necessary to incorporate the new requirements/ address related costs and potential liabilities in the event of inaccuracies. |

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| Specific Requirement | Stated Purpose | Applicability | Effective Date and Regulatory Guidance | Employer Action Required |
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| **Insurance Identification Cards with Cost Sharing Information**<br>• Plans must include specific information on physical and digital member ID cards in clear writing.<br>• Cards must reflect any plan deductibles, OOP limits, and a phone number and website for assistance and further information. | To ensure participants have current cost-sharing information readily available to them. | Group health plans (including grandfathered plans). | Plan years beginning on or after January 1, 2022.<br>Section 107 of the CAA NSA<br>Compliance based upon good faith reasonable interpretation of law applies pending regulatory guidance. (FAQ #4) | 1. Verify carrier or administrative service provider is preparing to issue cards meeting the new requirements and discuss any related fees. |
| **Advanced Explanation of Benefits (EOB)**<br>• Plans must provide a participant with an advance EOB for a service scheduled at least 3 days in advance or upon request.<br>• Provider must give plan an estimate of the anticipated charges. Plan must then provide advance EOB to participant with provider network status, contracted rate or INN info if provider is OON, estimated charges, cost-sharing obligations, YTD deductible and OOP information, medical management info and disclaimer that info provided is only an estimate based on items and services reasonably expected to be provided. | Protect participants from unexpected medical costs by providing cost-sharing estimates prior to scheduled care. | Group health plans (including grandfathered plans). | Original effective date: Plan years beginning on or after January 1, 2022.<br>Section 111 of CAA NSA<br>DOL FAQs issued August 20, 2021, delay enforcement pending issuance of guidance.<br>**FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (dol.gov)** | 1. Verify carrier or administrative service provider is prepared to coordinate with providers to ensure the EOB is timely provided to participants who schedule services or upon request.<br>2. Amend carrier or service contracts as necessary to incorporate the new requirements/ address related costs and potential liabilities in the event of inaccuracies.<br>3. Monitor regulatory guidance for additional updates. |
| **Price Comparison Tool**<br>• Plans must develop and maintain an online price comparison tool to enable participants to compare cost-sharing amounts for items and services from INN providers for a specific region.<br>• Plans must also make price comparison information available by phone. | Enable participants to better shop for healthcare services and potentially lower overall healthcare expenditures. | Group health plans (including grandfathered plans). | Original effective date: Plan years beginning on or after January 1, 2022<br>Section 114 of CAA NSA<br>Per August 20, 2021 FAQs, enforcement delayed to plan years beginning January 1, 2023. Regulators to propose rules to assess if compliance with the TiC Cost-Sharing Tool could also satisfy the CAA Price Comparison Tool requirement. (FAQ #3)<br>**FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (dol.gov)** | 1. Discuss with carrier or administrative service provider the development of the tool and any additional related costs.<br>2. Monitor regulatory guidance for additional updates. |

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