TRANSPARENCY AND CAA 2021 OBLIGATIONS OF GROUP HEALTH PLANS

This publication provides a high-level overview of important compliance requirements and effective dates under the Transparency in Coverage final rule, the No Surprises Act, and related federal legislation.

Recent federal legislation imposed significant new compliance obligations upon group health plan sponsors. These laws are designed to achieve several important objectives. One goal is to enable plan sponsors and participants to better evaluate healthcare options and make cost-conscious decisions by ensuring access to certain cost and quality of care information. 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 in October 2020.[1] 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, with all items and services required to be available via an online self-service tool for plan years beginning in 2024.

Subsequently, Congress passed the Consolidated Appropriations Act, 2021 (CAA) in December 2020. This stimulus relief measure incorporates patient protections and a variety of additional transparency and disclosure obligations that apply to group health plans (including grandfathered plans). Among other provisions, the CAA No Surprises Act (NSA) includes comprehensive surprise billing prohibitions.

On August 20, 2021, the DOL, IRS, and HHS released FAQs regarding the implementation of various CAA provisions.[2] This guidance provided temporary enforcement relief with respect to specific CAA provisions pending the issuance of regulatory guidance. Subsequently, implementing regulations were proposed or issued regarding some CAA provisions, but the industry is awaiting further guidance. Nonetheless, many CAA requirements, including the No Surprises Act (NSA) surprise billing prohibitions, took effect for plan years beginning on or after January 1, 2022.

Accordingly, group health plan sponsors should ensure that they are consulting with their carriers or ASO providers regarding implementing these requirements by the applicable deadlines. Although plan sponsors are ultimately responsible for compliance, most will rely heavily upon TPAs to timely satisfy their obligations. So, plan sponsors should routinely keep these mandates in mind when negotiating service agreements and vendor contracts for upcoming plan years. They should also budget for potential additional costs of compliance. 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 publication, presented in chart format, provides 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.

1. DOL, HHS, and IRS. "**Transparency in Coverage**," Federal Register, govinfo.gov, 2020.
2. DOL, HHS, and IRS. "**FAQs About Affordable Care Act and Consolidated Appropriations Act**," dol.gov, 2021.

TRANSPARENCY IN COVERAGE FINAL RULE

Specific Requirement	Stated Purpose	Applicability	Effective Date and Regulatory Guidance	Employer Action Required
Public Disclosure of Pricing Data Plans must disclose the following information: • Negotiated rates for INN covered items and services. • Historical OON billed charges and payment amounts for a recent 90-day period. • Prescription drug negotiated rates and historical net prices.* Required format is machine-readable files that must be posted on a public website and updated monthly. Per **ACA CAA FAQs Part 55, #22**, a plan without a public website may contract with a TPA to post the files on its public website for the plan. 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. Long-term goal is to lower overall healthcare costs by putting downward pressure on prices.	Applies to fully insured and self-insured non-grandfathered group health plans. Does not apply to account-based plans such as HRAs and FSAs, excepted benefits, or expatriate health plans. Limited exception with respect to historical OON disclosures may apply to small plans (for privacy protection reasons).	Original enforcement date: Plan years beginning on or after January 1, 2022. Final rule issued in 2020: **Transparency in Coverage** DOL CAA FAQs issued August 20, 2021, deferred enforcement date to July 1, 2022, for INN files and OON billed charges. *Per September 27, 2023, FAQs, prior deferred enforcement of prescription drug price file rescinded; implementation timeline to be announced in future guidance. **FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49** **FAQs About Affordable Care Act Implementation Part 61**	1. Consult with carrier or service provider regarding implementation. 2. Ensure that new, renewed, or extended contracts address these requirements. Fully insured plans can contract with carrier to assume liability for disclosures. Self-insured plans can contract with vendor but remain liable for disclosures. 3. Prospectively, use publicly disclosed data as a comparison tool for plan prices and contract negotiations.
Participant Cost-Sharing Tool Plans must disclose the following cost-sharing information at the request of a participant: • Estimate of cost-sharing liability for the covered item or service. • Accumulated amounts incurred to date. • INN rate (as a dollar amount) for an INN provider (includes negotiated rate and fee schedule). • OON allowed amount for item or service (if the provider is OON). • If a bundled payment arrangement, a list of the items or services. • Any prerequisites for the item or service. Required format is an internet-based self-service tool (or paper upon request).** 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. Reduce potential surprises in relation to participant out-of-pocket costs for healthcare services.	Applies to non-grandfathered group health plans and insurers. Does not apply to account-based plan such as HRAs and FSAs, excepted benefits, or expatriate health plans.	Cost-sharing tool must be available: • For **500 items and services** specified in the final rule for plan years beginning on or after January 1, 2023. • For all items and services for plan years beginning on or after January 1, 2024. Final rule issued in 2020: **Transparency in Coverage** **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) **FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49**	1. Consult with carrier or service provider regarding implementation. 2. Ensure that new, renewed, or extended contracts address these requirements. Fully insured plans can contract with carrier to assume liability for disclosures. Self-insured plans can contract with vendor but remain liable for disclosures. 3. Budget for implementation costs. 4. For the cost-sharing tool, develop instructional material for participants to use the tool effectively to compare healthcare costs.

CONSOLIDATED APPROPRIATIONS ACT, 2021

Specific Requirement	Stated Purpose	Applicability	Effective Date and Regulatory Guidance	Employer Action Required
Removal of Gag Clauses • 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. • Plans must also have electronic access to de-identified participant claims data that reflect the costs related to claims. • Contracts may include reasonable restrictions on public disclosure of data. • 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). Does not apply to account-based plans such as HRAs and FSAs, excepted benefits, or expatriate health plans.	December 27, 2020 (enactment date of the CAA). Section 201 of the CAA. **FAQs** issued February 23, 2023, address required attestation of compliance. Employers should visit the CMS website at **Gag Clause Prohibition Compliance Attestation | CMS** for instructions and to submit the attestation. The first attestation was due by December 31, 2023, for the period beginning December 27, 2020 (or the plan's effective date, if later) through the attestation date. Subsequent attestations are due by December 31 of each year thereafter for contracts entered into since the last attestation.	1. Review contracts with insurers, ASO providers, and TPAs offering access to provider networks to ensure compliance with the gag clause prohibition. 2. Amend contracts that contain prohibited restrictions. 3. Consult with counsel for assistance with contract review and amendments. 4. Timely submit initial and subsequent annual attestations to CMS by the applicable deadlines.

CONSOLIDATED APPROPRIATIONS ACT, 2021

Specific Requirement	Stated Purpose	Applicability	Effective Date and Regulatory Guidance	Employer Action Required
Mental Health Parity and Addiction Equity Act (MHPAEA) Nonquantitative Treatment Limitation (NQTL) Comparative Analysis • 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. • Background: NQTLs are limitations not tied to specific monetary or visit limits. Examples include utilization review requirements, experimental treatment exclusions, step therapy protocols, and standards for provider admissions to a network. • 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 (MH/SUD) benefits in a class cannot be more restrictive than those applied to medical or surgical (MED/SURG) benefits. • Analysis must be provided to the DOL, HHS, or state regulatory agency upon request. If deemed insufficient, plan will have a 45-day correction period to demonstrate compliance. Analysis must also be provided to participants upon written request.	Written analysis requirement is a formalization of the existing NQTL compliance requirements.	Plans that offer MH/SUD and MED/SURG benefits and impose NQTLs on the MH/SUD benefits. Does not apply to 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 Section 203 of the CAA. DOL issued FAQs on MHPAEA Implementation and the CAA. **FAQs Part 45** On July 25, 2023, the DOL, HHS, and IRS issued: • **MHPAEA Proposed Rules**, which includes a 3-part NQTL analysis test incorporating outcomes data, specific comparative analysis elements, and helpful NQTL examples. • A DOL **Technical Release**, which focuses on network adequacy and composition. • 2023 **Report to Congress** and **Enforcement Fact Sheet**, which highlight regulatory enforcement efforts, comparative analyses deficiencies and corrective actions, and priority focus areas (e.g., impermissible exclusions such as ABA therapy treatment, and preauthorization, concurrent review, and provider network admission standards).	1. Contact carrier or ASO provider to request a copy of any NQTL analysis that was performed. Insurers are also subject to these requirements, so an analysis may be available for fully insured plans. Self-insured plans should consult with the ASO provider to see if an NQTL analysis was prepared. 2. Ensure that new and renewed contracts entered into after February 10, 2021, address the analysis requirement and that the carrier or TPA will provide the analysis. 3. Review recent guidance and DOL MHPAEA Self-Compliance Tool, which outlines 5 step NQTL analysis. **Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act** 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. 5. Establish a procedure for ongoing compliance and participant requests for the comparative analysis.

CONSOLIDATED APPROPRIATIONS ACT, 2021

Specific Requirement	Stated Purpose	Applicability	Effective Date and Regulatory Guidance	Employer Action Required
Prescription Drug and Healthcare Spending Reporting • Plans must report certain information on prescription drug costs and spending to the DOL, HHS, and Treasury, including: o General plan information (e.g., plan year, participant count, and states where coverage is offered); o The plan's 50 most dispensed brand prescription drugs and total paid claims for each; o The plan's 50 most costly drugs by total annual spending and annual amount spent for each; o The 50 drugs with the greatest annual cost increase and change in amount of each; o Total spending by the plan (broken down by types of service, such as hospital and primary care); o Drug spending by plan and participants and monthly premiums paid by employer and employee; o 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. 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. Does not apply to account-based plans such as HRAs and FSAs, excepted benefits, or expatriate health plans.	December 27, 2021, but relief allowed plans to submit 2020 and 2021 data by January 31, 2023. Subsequent reports are due annually by June 1. Data File Submission Instructions for RxDC reporting is available at: **Prescription Drug Data Collection (RxDC) | CMS** Section 204 of the CAA. **Interim Final Rule effective December 23, 2021**	1. Consult with carrier (for fully insured plans) or TPA/PBM (for self-insured plans) to determine if they will report to CMS for the plan and respond to TPA/PBM data requests. Self-insured plans must submit to CMS any data not submitted by the TPA/PBM. 2. If carrier or TPA agrees to assist with reporting, obtain written confirmation and amend service contracts to reflect each party's obligations. 3. Monitor CMS updates for specific reporting requirements. 4. Review the biannual compilations when released by the regulators, which can serve as a benchmark for future prescription drug spending and negotiations.
Service Provider Compensation Disclosure • Prior to a contract or renewal date, covered service providers must provide written disclosure to the plan sponsor/fiduciary of any compensation (direct or indirect) they will receive for services provided on behalf of the plan. • Applies if provider receives $1,000 or more per year in compensation. • Disclosure requires a statement of services (including, if applicable, fiduciary services) and all expected compensation (whether transaction-based, an incentive, etc.). • 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. Disclosure is intended to provide plan sponsors with sufficient information to determine the reasonableness of service provider compensation and identify potential conflicts of interest. 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. Does not apply to life and disability plans, HSAs, or non-ERISA plans.	December 27, 2021 Upon the effective date, disclosure is required before a contract is entered, extended, or renewed. (Contracts entered before December 27, 2021, are exempt, unless renewed or extended.) **DOL Field Assistance Bulletin 2021-03: Temporary Enforcement Policy**	1. Review existing service provider contracts to determine the renewal or extension date. 2. Request compensation disclosure if not provided before entering, extending, or renewing a service provider contract on or after December 27, 2021. 3. Review disclosure for accuracy and reasonableness and if necessary, send written request to provider for clarification. 4. Retain copy of disclosure for fiduciary records. Establish a procedure for ongoing compliance.

CONSOLIDATED APPROPRIATIONS ACT, 2021

Specific Requirement	Stated Purpose	Applicability	Effective Date and Regulatory Guidance	Employer Action Required
Surprise Billing and Independent Dispute Resolution (IDR) • 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). • 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. Limits apply to OON emergency services (including by air ambulance, but not ground ambulance), some OON post-stabilization services, and certain OON non-emergency services (e.g., radiology) at INN hospitals and ambulatory surgical centers. • Balance billing for protected items and services is prohibited. • In very limited situations and upon notice, consent can be obtained from a participant for OON care and extra costs. • 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 (termed the Qualifying Payment Amount or "QPA"). • 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. • Plan/carrier or provider can initiate IDR process only after exhausting a 30-day negotiation period. After an IDR entity is selected, each party must submit its offer within 10 days. IDR entity must select one party's offer, taking into account certain specified factors. The IDR process is expected to be conducted through the designated portal. • 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.	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. Reduce possibility of providers using surprise billing as leverage to get higher payments, which result in higher premiums and healthcare costs overall. 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). Does not apply to retiree-only plans, excepted benefits, or HRAs.	Plan years beginning on or after January 1, 2022. Provisions of the CAA NSA Interim Final Rule (IFR), **Requirements Related to Surprise Billing; Part I**, effective September 13, 2021. IFR, **Requirements Related to Surprise Billing; Part II**, effective October 7, 2021. Final Rule, **"Requirements Related to Surprise Billing"**, effective October 25, 2022. **Surprise Billing FAQs**, released August 19, 2022. Following numerous lawsuits brought by the Texas Medical Association, FAQs and final rules were issued regarding the federal IDR process and fees. Further guidance is expected. See **FAQs** and **Final Rules**.	1. Consult with carrier (for fully insured plans) or ASO provider (for self-insured plans) to ensure contract terms reflect responsibilities regarding surprise billing, disclosures, timely payments or denials, negotiations, and the IDR process. 2. Update plan documents and SPDs as necessary to incorporate the surprise billing and IDR rules. 3. Post required notice of surprise billing protections on website and include in each EOB. See **DOL Model Notice**. 4. Monitor impact on plan costs. 5. Evaluate whether the stop-loss contract should be modified due to potential changes in costs and timeframes to finalize provider claims. 6. Monitor updates for additional information on IDR process.

CONSOLIDATED APPROPRIATIONS ACT, 2021

Specific Requirement	Stated Purpose	Applicability	Effective Date and Regulatory Guidance	Employer Action Required
Continuity of Care Provisions • Plans must provide notice to "continuing care patients" when a plan's contract with an INN provider is terminated. • 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 a terminal illness from the provider. • Notice must explain how to elect transitional coverage for up to 90 days at INN rates. • 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. Section 113 of CAA NSA. 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.) **FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49**	1. Consult with carrier or ASO provider to ensure they are prepared to comply with the Continuity of Care requirement and provide the required disclosures, when applicable. 2. Amend carrier or ASO provider contracts as necessary to address the Continuity of Care requirements and related costs. 3. Update plan documents as appropriate.
Provider Directories • Plan must maintain an accurate and current directory of INN providers and facilities on a public website. • Information in the directory must be updated and verified at least every 90 days. Updates must be made within 2 days of notice by providers. • Plans must respond within 1 business day to a participant request for information regarding whether a provider is INN and must retain the communication in the participant's file for at least 2 years. • If a directory or communication incorrectly reflects that a provider is INN, the INN cost sharing applies, and payments are applied to the respective INN deductible and OOP limit.	Protect participants from unexpected medical costs due to outdated INN provider directories.	Group health plans (including grandfathered plans).	Plan years beginning on or after January 1, 2022. Section 116 of CAA NSA. 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.) **FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49**	1. Consult with carrier or ASO provider to confirm they are complying with this provision and timely update directories, respond to participant requests, maintain necessary records, and update EOB and website with required additional information. 2. Amend carrier or ASO provider contracts as necessary to incorporate the Provider Directories requirements and to address related costs and potential liabilities in the event of inaccuracies.

CONSOLIDATED APPROPRIATIONS ACT, 2021

Specific Requirement	Stated Purpose	Applicability	Effective Date and Regulatory Guidance	Employer Action Required
Insurance Identification Cards with Cost-Sharing Information • Plans must include specific information on physical and digital member ID cards in clear writing. • 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. Section 107 of the CAA NSA. Compliance based upon good faith reasonable interpretation of law applies pending regulatory guidance. (FAQ #4)	1. Confirm that carrier or ASO provider is issuing cards that meet the ID Cards requirements and discuss any related fees.
Advanced Explanation of Benefits (EOB) • Plans must provide a participant with an advanced EOB for a service scheduled at least 3 days in advance or upon request. • Provider must give plan an estimate of the anticipated charges. Plan must then provide advanced EOB to participant with: o Provider network status; o Contracted rate or INN info if provider is OON; o Estimated charges; o Cost-sharing obligations; o YTD deductible and OOP info; o Medical management info; o Disclaimer stating 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. Section 111 of CAA NSA. DOL FAQs #5 and #6, issued August 20, 2021, delay enforcement pending issuance of guidance. **FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49** Request for information published September 16, 2022: **Federal Register: Request for Information; Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals**	1. Confirm that carrier or ASO provider is prepared to coordinate with providers to ensure the EOB is timely provided to participants who schedule services or upon request. 2. Amend carrier or service contracts as necessary to incorporate the Advanced EOB requirements and to address related costs and potential liabilities in the event of inaccuracies. 3. Monitor regulatory guidance for additional updates.
Price Comparison Tool • 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. • 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. Section 114 of CAA NSA. 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) **FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49**	1. Discuss with carrier or ASO provider whether TiC internet self-service tool can accommodate requests by phone in anticipation of possible consolidation of this CAA requirement with the TiC tool. 2. Monitor regulatory guidance for additional updates.

CONSOLIDATED APPROPRIATIONS ACT, 2021

Specific Requirement	Stated Purpose	Applicability	Effective Date and Regulatory Guidance	Employer Action Required
Air Ambulance Reporting For calendar years 2022 and 2023, plans must report to HHS detailed data for each air ambulance services claim received or paid for, including but not limited to the service date, specific healthcare billing code, service provider, transport information, and whether the provider had a contract with the plan. Specific claim adjudication and payment information is also required.	HHS intends to use the combined information from the reports to issue a comprehensive public report on air ambulance services, as required under the CAA.	Group health plans (insured or self-insured), including grandfathered plans. Does not apply to account-based plans such as HRAs and FSAs, excepted benefits, or expatriate health plans.	Section 106(b) of the No Surprises Act **Proposed Rule, "Requirements Related to Air Ambulance Services"** In February 2023, CMS **announced** that no reporting will be due until after final rules are published.	1. Contact carrier (for fully insured plans) or TPA (for self-insured plans) to determine if they will report to HHS on the plan's behalf. A self-insured plan may need to report directly if the TPA will not. 2. Enter a written agreement that defines each party's obligations. • An insured plan will satisfy the requirements if the insurer provides the information pursuant to a written agreement. • A self-insured health plan can contract with a TPA to report the required information, but the plan remains responsible for any reporting failures. 3. Monitor regulatory guidance for additional updates.

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