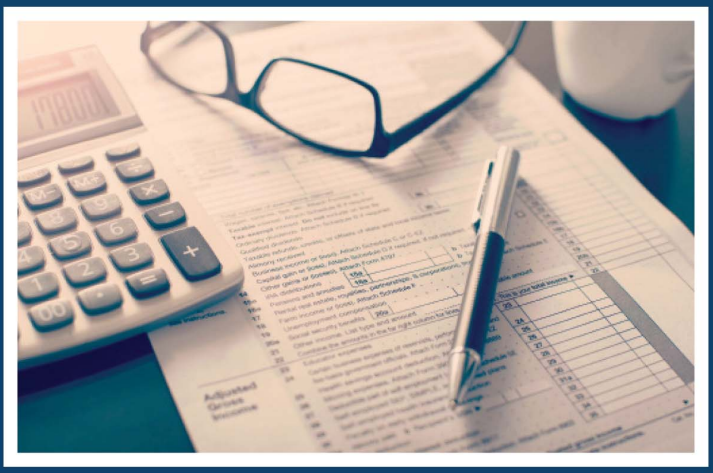
NEW HEALTH PLAN TRANSPARENCY REQUIREMENTS

NOVEMBER 2021



Consolidated Appropriations Act and Final Rule on Health Care Transparency: Employee Benefits Provisions

The **Consolidated Appropriations Act, 2021 (CAA)**, which was signed into law on Dec. 27, 2020, includes many benefits and tax provisions affecting employers, group health plan sponsors, health benefits brokers and health insurance issuers**.** Some provisions are currently effective, while others begin on future dates. The provisions related to health plan coverage apply to both insured and self-insured group health plans.

In addition, on October 29, 2020, the Departments of Labor, Health and Human Services and the Treasury issued a **Final Rule on Health Care Transparency** that imposes new transparency requirements on group health plans and health insurers in the individual and group markets. These provisions apply to non-grandfathered coverage, including both insured and self-insured group health plans.

On August 20, 2021, the Departments of Labor, Health and Human Services and the Treasury issued Frequently Asked Questions deferring the enforcement of some requirements to a later date, as noted at the end of this document.

This Compliance Overview summarizes the employee benefits provisions relating to surprise medical billing, health plan transparency and mental health parity under the Consolidated Appropriations Act and the Final Rule on Health Care Transparency as well as effective dates and delayed enforcement, where applicable.

Links and Resources

- Legislative text of the Consolidated Appropriations Act, 2021
- Summary of Appropriations Provisions by the House Appropriations Committee
- Final Rule on Health Care Transparency
- FAQs

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Ban on Surprise Medical Bills under the CAA

The No Surprises Act, included in the CAA, is a ban on surprise medical bills. The provisions of the Act apply to plan or policy years beginning on or after **Jan. 1, 2022.**

Surprise medical bills occur when patients unexpectedly receive care from out-of-network health care providers. For example, a patient may go to an in-network hospital for treatment, such as surgery or emergency care, but an out-of-network doctor may be involved in the patient's care. Patients often cannot determine the network status of these providers during treatment in order to avoid the additional charges, and are often not involved in the choice of provider at all.

The No Surprises Act applies to surprise bills from doctors, hospitals and air ambulances. It will prohibit these providers from billing patients who have health coverage for unpaid balances. Rather, providers will have to work with the group health plans or health insurance issuers to determine the appropriate amount to be paid by the plan or issuer, under the methodology provided in the Act. The Depts. of Health and Human Services, Labor and the Treasury will work together to issue regulations regarding this methodology and other requirements of the Act.

Health Care Transparency under the CAA

The CAA makes a number of changes to increase transparency in health care. These changes have varying effective dates and impact health plans, health insurance issuers, brokers and consultants.

-Removal of Gag Clauses

The law bans gag clauses in contracts between providers and health insurance plans that prevent:

- Enrollees, plan sponsors or referring providers from seeing cost or quality of care information or data on providers.
- Plan sponsors from accessing de-identified claims data that could be shared, under Health Insurance Portability and Accountability Act (HIPAA) business associate agreements, with third parties for plan administration and quality improvement purposes.

Group health plans or issuers must annually submit an attestation of compliance with these requirements. The ban on gag clauses is effective on the CAA's enactment date of **Dec. 27, 2020**. The Departments intend to issue further guidance on the attestation.

-Disclosure of Broker Compensation

The CAA creates new requirements for brokers and consultants to disclose to ERISA-covered group health plan sponsors any direct or indirect compensation they may receive for referral of services. Similar disclosure to enrollees in the individual market or enrollees purchasing short-term limited duration insurance is required for referral of coverage. These new disclosure requirements generally apply to contracts entered into, extended or renewed on **Dec. 27, 2021**.

-Price Comparison Tool

Offer price-comparison guidance by telephone and make available on the public website of the plan or insurer a price-comparison tool that (to the extent practicable) allows an enrolled individual to compare the amount of cost sharing that the individual would be responsible for paying for items and services by a participating provider and by geographic region. **Effective Jan. 1, 2022, delayed to Jan. 1, 2023.**

-Advanced Explanation of Benefits

After submission of charges by a provider or facility, give a participant or dependent a timely Advanced Explanation of Benefits (EOB) notification in clear and understandable language, including certain elements. **Effective Jan. 1, 2022, delayed pending further rulemaking.**

-Enhanced ID Cards

Include in clear writing, on any physical or electronic plan or insurance identification card issued to participants or dependents, deductibles, the out-of-pocket maximum and a telephone number and internet website address to seek network and other consumer-assistance information. **Effective Jan. 1, 2022**.

-Continuity of Care Notice

Notify each participant who is a "continuing-care patient" with respect to a provider/facility at the time of a termination of a contract (or change in terms of participating), on a timely basis of the termination and the individual's right to elect continued transitional care from the provider/facility under the same terms and conditions as prior to the termination (for a limited time period). Generally continuing-care patient are those being treated for serious conditions, including pregnancy. **Effective Jan. 1, 2022.**

-Online Provider Directories

Create a process to verify the accuracy of their provider database at least every 90 days. **Effective Jan. 1, 2022.**

-Reporting on Pharmacy Benefits and Drug Costs

The CAA requires group health plans to report information on plan medical costs and prescription drug spending to the Secretaries of HHS, Labor and the Treasury. Specifically, plans must report the following:

- The beginning and end dates of the plan year.
- The number of enrollees.
- Each state in which the plan is offered.
- The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan, and the total number of paid claims for each drug.
- The 50 most costly prescription drugs with respect to the plan by total annual spending, and the annual amount spent by the plan for each drug.
- The 50 prescription drugs with the greatest increase in plan expenditures over the prior plan year, and for each drug, the change in amounts expended by the plan in each plan year.
- Total spending on health care services by the group health plan, broken down by the type of costs, the average monthly premium paid by employers (as applicable) and by enrollees, and any impact on premiums by rebates, fees and any other remuneration paid by drug manufacturers to the plan.
- Any reduction in premiums and out-of-pocket costs associated with rebates, fees or other remuneration.

No confidential information or trade secrets can be included in the report. The reporting requirement is effective **Dec. 27, 2021,** and no later than **June 1** of each year thereafter**. Delayed pending further rulemaking**.

-Mental Health Comparative Analysis

The CAA includes provisions that strengthen enforcement of existing mental health parity laws and increase transparency with respect to how health plans are applying these laws. In particular, it requires group health plans and health insurance issuers to conduct comparative analyses of the nonquantitative treatment limitations (NQTLs) used for medical and surgical benefits as compared to mental health and substance use disorder benefits. The comparative analyses, and certain other information, must be made available upon request to applicable agencies **beginning Feb. 10, 2021**.

If, upon review of the analyses, the Secretaries of Labor, HHS, and the Treasury find that a plan is out of compliance with mental health parity laws, corrective actions will be specified for the plan to come into compliance, which the plan will have 45 days to implement. If the plan is still not in compliance after those 45 days, the plan must notify all individuals enrolled in the noncompliant plan within seven days.

Health Care Transparency under the Final Rule on Health Care Transparency

The final rule requires plans and issuers to disclose:

- **Price and cost-sharing information to participants, beneficiaries and enrollees upon request:** Personalized cost-sharing information must be made available through an internet-based self-service tool and in paper form upon request. An initial list of 500 shoppable services will be required for plan years beginning on or after **Jan. 1, 2023**. The remainder of all items and services will be required for plan years beginning on or after **Jan. 1, 2024**.

- **In-network provider-negotiated rates and historical out-of-network allowed amounts on their website:** For plan years beginning on or after **Jan. 1, 2022**, plans and issuers will also be required to disclose on a public website their in-network negotiated rates, billed charges and allowed amounts paid for out-of-network providers, and the negotiated rate and historical net price for prescription drugs. **In-network and billed charges files delayed to Jul. 1, 2022. Prescription drug file delayed pending further rulemaking.**

Deferred Enforcement of Some Requirements

On Aug. 20, 2021, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments) issued frequently asked questions (FAQs) regarding the implementation of the No Surprises Act and transparency provisions of the Consolidated Appropriations Act, 2021 (CAA) and the Healthcare Transparency Final Rule.

The Departments will defer enforcement of the rules regarding:

- Publishing transparency in coverage machine-readable files related to prescription drug pricing under the Healthcare Transparency Final Rule **pending further rulemaking**;
- Publishing other types of machine-readable files under the Healthcare Transparency Final Rule until **July 1, 2022**;
- Providing a price comparison tool under the CAA until **Jan. 1, 2023**;
- Providing a good faith estimate of expected charges and Advanced Explanation of Benefits to certain individuals under the CAA **pending further rulemaking**; and
- Reporting of pharmacy benefit and drug costs under the CAA **pending further rulemaking**.

Other Guidance

The Departments plan to issue regulations on the interaction of the CAA and the Transparency in Coverage Final Rule as well as the provider directory and continuity of care requirements. Regulations may not be issued until after Jan. 1, 2022. Until then, plans and issuers are expected to use good faith, reasonable interpretations of the statute.

They do not expect to issue regulations on provisions prohibiting gag clauses or balance billing disclosure requirements. Plans and issuers are expected to use good faith, reasonable interpretations of the statutory requirements.

The Departments also provided an example of a plan or insurance identification card that would be compliant with the transparency requirements for those cards and clarified that grandfathered health plans are generally subject to the CAA's requirements.

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