CAA and Transparency in Coverage Provisions Impacting Health and Welfare Plans

Summary of provisions included in the Consolidated Appropriations Act, 2021 (CAA), and Transparency in Coverage (TiC) provisions.

Provision	Affected Health Plans	Requirements Oveview
No Surprises Act (NSA) – Balance Billing Protection	All group medical plans: ▪ Self-funded plans are subject to the NSA unless the plan choses to "opt-in" to an available state program. ▪ Fully insured plans are subject to the NSA unless state law or the All-Payer Model Agreement applies.	Applies to group health plans that begin on or after January 1, 2022. With respect to out-of-network (OON) emergency services, non-emergency services furnished by an OON provider in an in-network facility and OON air ambulance services, the NSA requires the services be provided: ▪ Without cost-sharing requirements that are greater than those that would apply if the services were provided in-network; ▪ By calculating cost-sharing requirements as if the total amount that would have been charged for the services were equal to the "recognized amount" for such services; and ▪ By counting any cost-sharing payments toward any in-network deductible or out-of-pocket maximum (OOPM) (including the annual limit on cost-sharing). There is a prescribed process for plan and payer payment, including an Independent Dispute Resolution (IDR) process when the payment is disputed. **Notice requirement.** Plans must make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits (EOB) for an item or service with respect to which the NSA applies, a notice of the protections under the NSA. The model NSA disclosure has been updated for use by group health plans and carriers for plan years beginning on or after January 1, 2023. Before this date, a plan may use either the original model notice or the updated version. If the group health plan does not have a website, the plan may satisfy the public posting requirement through agreement with a carrier/third-party administrator (TPA) to post the information on its public website where information is normally made available to participants. **Emergency services.** Final rules clarify that a determination of what constitutes an emergency medical condition cannot be based on final diagnosis code. Rather all pertinent documentation must be considered and should focus on the presenting symptoms. Plan sponsors should discuss compliance with carriers/TPAs. For additional details, see USI's National Compliance Update, First Guidance on Surprise Medical Billing Issued (July 22, 2021).
Air Ambulance Reporting	All group medical plans	**Air Ambulance Disclosure**. Plans must submit data regarding air ambulance services on a calendar year (CY) basis for 2022 and 2023 within 90 days of the end of the calendar year. ▪ **For CY 2022, by March 31, 2023** regardless of plan year. ▪ **For CY 2023, by March 31, 2024** regardless of plan year. No further guidance has been issued to date.

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Pharmacy Benefits and Cost Reporting	All group medical plans	▪ Effective December 27, 2021, group health plans and carriers will be required to report annually to the government specific information on pharmacy benefits and costs. ▪ This includes the 50 most common brand dispensed prescriptions, the 50 most costly drugs, and the 50 drugs with the greatest year-over-year costs. This is in addition to other information including the impact of rebates on premiums and out-of-pocket costs. ▪ **Reporting for calendar year 2020, 2021 is due by December 27, 2022.** ▪ For subsequent calendar years, reporting is due by the following June 1. **For calendar year 2022, the reporting is required by June 1, 2023.** ▪ Fully insured plans may enter into a written agreement with their carriers to transfer responsibility and liability for reporting to the carrier (recommended). Self-funded plans may enter into a written agreement with their TPAs or pharmacy benefit managers (PBMs) to fulfill reporting function on behalf of the plan, however plan (and plan sponsor) remain liable for failures. Coordination with TPAs and PBMs is needed to facilitate accurate and timely reporting.
ID Cards Transparency	All group medical plans	For plan year beginning on or after January 1, 2022, group health plan ID cards (physical or electronic) must include (in clear writing): ▪ Any applicable deductibles; ▪ Any applicable out-of-pocket maximum limitations; and ▪ A telephone number and website address for individuals to seek consumer assistance. Further regulations are expected. Plans should implement this requirement using good faith, reasonable interpretation of the statute. The Departments will not deem a plan out of compliance where the ID card is issued to participants and beneficiaries with the following: ▪ The applicable major medical deductible and applicable out-of-pocket maximum; ▪ A telephone number and website address for consumer assistance, and to access additional applicable deductibles and maximum out-of-pocket limits (including a scannable QR code on the ID card).
Continuity of Care	All group medical plans	For plan years beginning on or after January 1, 2022, a patient in a course of treatment[1] with an in-network provider/facility that becomes OON must be notified and given an opportunity to receive coverage on the same terms for up to 90 days. Further regulations are expected. Plans should implement this requirement using good faith, reasonable interpretation of the statute.
Prohibition on Gag Clauses on Price and Quality Data	All group medical plans	Plans and carriers may not enter into an agreement with a provider, network, TPA or other service provider offering access to a network of providers that directly (or indirectly) restricts the plan from: ▪ Providing provider-specific cost or quality of care information or data; ▪ Electronically accessing de-identified claims and encounter data for each participant or beneficiary; and ▪ Sharing such information, consistent with applicable privacy regulations.

[1] Generally, this provision applies to serious and complex conditions, pregnancy, terminal illness, individuals undergoing a course of institutional or inpatient care, or scheduled to undergo nonelective surgery (or post-operative care related to the surgery).

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		Disclosure. Annually plans must submit an attestation of compliance. Future guidance expected as to how plans will submit this information and collection will begin in 2022. At this time, no guidance has been issued. Plans should implement this requirement using good faith, reasonable interpretation of the statute.
Compensation Transparency	ERISA-covered group health plans	▪ Effective for contracts issued on or after December 27, 2021. ▪ Fiduciaries of a group health plan (regardless of size) must obtain a written disclosure of services and compensation from "brokers" and "consultants" earning at least $1,000 in direct or indirect compensation. ▪ Definition of broker/consultant appears broad, may include parties who are not considered traditional brokers/consultants (e.g., PBMs, wellness vendors, and TPAs). ▪ Fiduciaries should receive the disclosure reasonably in advance of each contract date and renewal date. Fiduciaries will be required to report brokers/consultants to the U.S. Department of Labor (DOL) if they do not comply.
MHPAEA – Comparative Analysis	Employers with more than 50 employees offering group health plan coverage that includes Mental Health and/or Substance Use Disorder (MH/SUD) benefits Non-grandfathered insured plans, including small group coverage	Group health plans must conduct a comparative analysis of the design and application of Non-Quantitative Treatment Limits (NQTLs) and provide to the DOL (or participants and beneficiaries) upon request. Further regulations expected. Self-funded plans and/or carveout arrangements (i.e., PBM carveout) will need to work with TPAs to determine capabilities for providing such a report. Requirement took effect February 10, 2021.
Good Faith Estimate (GFE) and Advance EOBs	GFEs - Providers and facilities Advance EOBs – all group medical plans	▪ Upon the scheduling of items or services (or upon patient request) providers are required to (1) inquire whether the individual has health insurance coverage and (2) provide GFE of the expected charges for furnishing those items and services to the group health plan. ▪ The group health plan, after receiving the GFE, must send the participant or beneficiary an Advance EOB.[2] **Enforcement Relief**. While set to take effect for plan years beginning on or after January 1, 2022, ***enforcement has been deferred until further guidance is issued***, including establishing appropriate data transfer standards between providers and plans. Any future guidance will include a prospective applicability date to provide additional time for compliance.
Transparency in Coverage (TiC) – Machine-Readable Files	Non-grandfathered medical plans	Plans and carriers must make public three machine-readable files (MRFs) disclosing (1) in-network rates, (2) out-of-network (OON) allowed amounts and billed charges, and (3) negotiated rates and historical net prices for covered prescription drugs. ▪ Deadline to publish (1) and (2) above is: – **July 1, 2022,** for a plan year that begins between January 1, 2022 and July 1, 2022

[2] Specifically, the Advance EOB must include:
- the network status of the provider or facility;
- the contracted rate of the item or service;
- the good faith estimate received from the provider;
- a good faith estimate of the amount the plan is responsible for paying for the item or service and the amount of any cost-sharing the individual will be responsible for paying; and
- disclaimers explaining whether the item or service is subject to any medical management techniques.

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		– For plan years that **begin after July 1, 2022, the month in which the plan year begins.** ▪ Requirement to publish machine-readable files for prescription drugs (3) delayed pending further rulemaking. Plan sponsors should confirm whether carriers and/or TPAs will prepare and publicly post files as required under the law. Employers sponsoring a fully insured arrangement can rely on the carrier to post this information when there is an agreement between the plan and the carrier. If the **carrier fails to provide full or timely information, *the carrier* (not the plan/employer) is liable.** While a self-funded health plan may contract with a TPA to provide the required disclosure, ***the plan is ultimately responsible***. If a group health plan does not have its own public website, nothing in the final rules requires the plan to create its own website for the purposes of providing a link to where the MRFs are publicly available. A plan may satisfy the disclosure requirement by entering into a written agreement under which a TPA posts the machine-readable files on its public website on behalf of the plan. However, ***if the TPA fails to do so, the plan is liable***. Files must be updated monthly on an ongoing basis.
TiC – Price Comparison Tools (Including CAA[3] Requirements)	All group medical plans[4]	For plan years that **begin on or after January 1, 2023**, plans must provide for the disclosure of cost sharing information in advance of receiving care through an internet-based self-service tool, in paper form or by telephone (added by CAA). The initial compliance deadline applies to 500 identified items and services. Full compliance required for plan years beginning on or after January 1, 2024. The CAA included similar disclosure requirements that are largely duplicative and set to take effect for plan years beginning on or after January 1, 2022. **Enforcement of CAA requirements are deferred until the first plan year on or after January 1, 2023** to align with the TiC rules. Plans are encouraged to continue to make existing price comparison tools available to participants and beneficiaries and works toward full compliance.

[3] Consolidated Appropriations Act, 2021.

[4] While the specific transparency in coverage price comparison regulations only apply to non-grandfathered plans, based on guidance in FAQ 49 the requirements under the CAA are largely duplicative and will apply to all group health plans (regardless of grandfathered status).