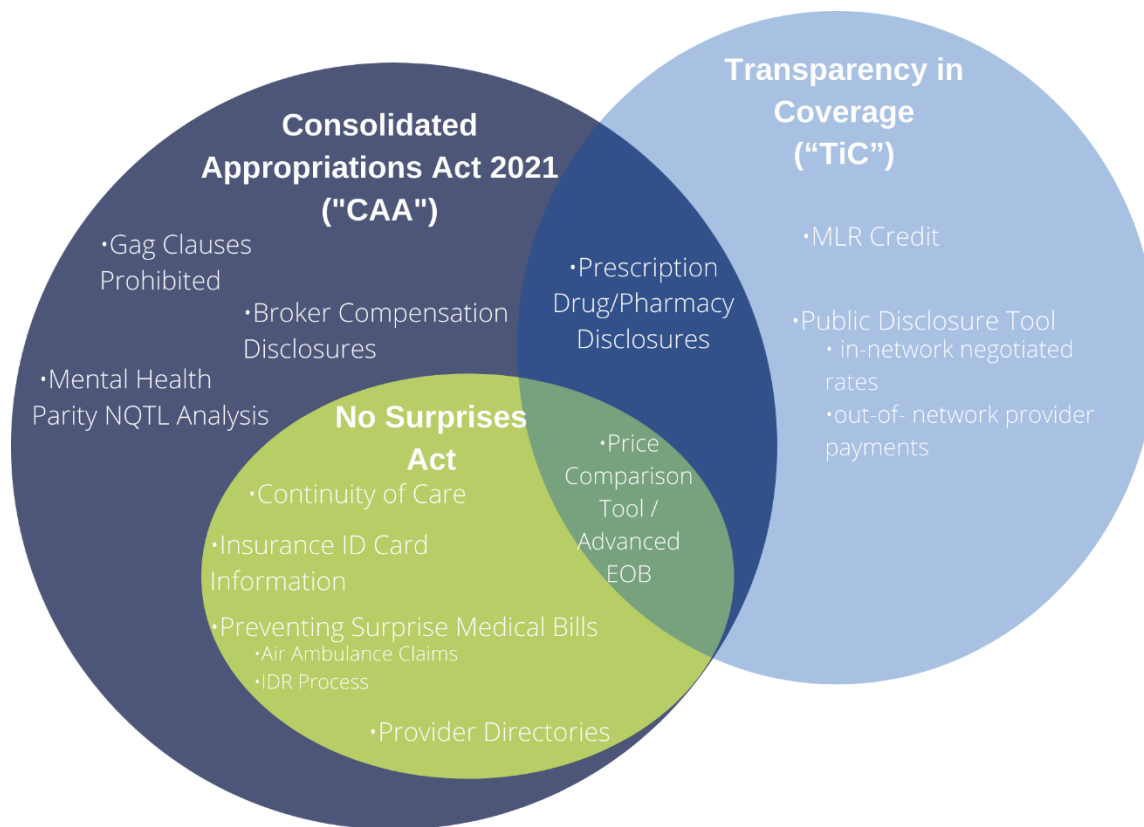


You Are Here: A Mall Directory for Healthcare Transparency Requirements

The old adage “you can’t get where you’re going unless you know where you are” has never seemed more true than when applied to the current mélange of healthcare transparency guidance. Fortunately, a fading relic from America’s malls may provide a helpful way to think about organizing and navigating the transparency guidance – the mall directory. A precursor to the search bar, mall directories would tell you where you were and provide an easy to grasp layout of the stores. It also would allow you to retrace your steps and provide information to help inform where you might like to go next. Similarly, this post seeks to orient group health plan sponsors regarding where they are with respect to the health care transparency guidance, provide a high-level overview of the guidance issued to date, briefly review the most recent guidance, and offer some recommendations regarding next steps for plan sponsors.

Where We Are



The health care transparency requirements stem from the Consolidated Appropriations Act of 2021 (“CAA”) final regulations promulgated under the Patient Protection and Affordable Care Act (“ACA”). The core directives have been modified by subsequent guidance from the Departments of Health and

Human Services (“HHS”), Treasury (“Treasury”), and Labor (“DOL”) (collectively, the “Departments”), as well as the Office of Personnel Management (“OPM”). The core directives are:

[Transparency in Coverage Final Rule \(“TIC”\)](#): Contains three primary changes for group health plans and health insurance carriers:

1. [MLR Credit](#) (*currently effective 7/31/2021*): Allows health insurance carriers to receive credit in their medical loss ratio (“MLR”) calculations for savings they share with enrollees that result from the enrollees shopping for, and receiving care from, lower-cost, higher-value providers.
2. [Public Disclosure Tool](#) (*currently effective 7/1/2022*): Requires plans to create an online tool that makes three types of detailed cost-sharing information about the plan’s health care providers available to the public in machine-readable files:
 - The negotiated rate between the plan and in-network providers for all covered services,
 - The plan’s payments to and billed charges from out-of-network providers, and
 - [Prescription Drug Disclosure*](#) (*deferred enforcement pending additional rulemaking*): Negotiated rates and historical net prices for all covered prescription drugs (including the cost of drugs obtained through a pharmacy benefit manager (PBM)).
3. [Price Comparison Tool*](#) (*currently effective beginning with the 2023 plan year*): Requires plans to provide plan members with personalized out-of-pocket cost information that will allow them to estimate medical costs prior to an episode of care. This disclosure must include information regarding a particular member’s cost-sharing obligations, like an explanation of benefits (EOB) form, beginning initially with a list of 500 “shoppable services” (such as tonsil removal, knee replacement, x-rays, and colonoscopies) on 1/1/2023, followed by all remaining services on 1/1/2024.

[Consolidated Appropriations Act of 2021 \(“CAA”\)](#): Contains several requirements regarding health care transparency, most of which exist under the No Surprises Act, which was signed into law as part of the CAA, and some of which overlap requirements in the TIC. (The overlapping requirements are indicated by an “*.”) The requirements were generally intended to be effective January 1, 2022, but many have been delayed by subsequent guidance. Below is an overview of each main requirement:

No Surprises Act

- [Continuity of Care](#) (*effective with 2022 plan year – good faith compliance standard*): Plans must provide 90 days of continued in-network coverage, even if the treating provider leaves the network, for plan members receiving certain types of in-network care (*e.g.*, a member undergoing a course of treatment for serious and complex condition or who is scheduled to undergo nonelective surgery, pregnant women, and terminally ill patients).
- [Advanced EOB*](#) (*deferred enforcement pending additional rulemaking*): Providers must send a good faith estimate of the expected cost of an episode of care to the plan *before* the service so that plans can provide the member with an “advance EOB” containing several pieces of information, including whether the provider is in network, the provider’s good faith estimate, the amount the plan will pay, and an estimate of the member’s remaining cost sharing obligation.

- Insurance ID Card Information (*effective with 2022 plan year – good faith compliance standard*): Physical or electronic ID cards must contain information regarding: (1) in-network and out-of-network deductibles, (2) out-of-pocket-maximum for the coverage, and (3) a telephone number and website address where members may seek assistance.
- Preventing Surprise Medical Bills:
 - Air Ambulance Claims (*effective with 2022 plan year*): If a plan covers in-network air ambulance services, members can only be required to pay in-network cost sharing amounts for air ambulance services, and services will not be able to balance bill members.
 - Independent Dispute Resolution (IDR) Process (*effective with 2022 plan year*): For medical bills that arise from out-of-network emergency care or services provided by out-of-network providers at an in-network facility that are ancillary or performed without the patient’s consent, the patient will be required to pay only the in-network cost-sharing amount (which will be applied to member’s deductible and out-of-pocket maximums), and providers will not be able to balance bill members for remaining amounts.
- Price Comparison Tool* (*deferred enforcement to 2023 plan year to align with TiC*): Plans must offer a price comparison tool (on a website and by phone) that allows members to compare their cost-sharing obligations for a particular item or service, and considers their specific circumstances, including geographic region and participating providers.
- Provider Directories (*effective with 2022 plan year – good faith compliance standard*): Plans must ensure in-network provider directories are publicly available and are up to date, must develop a process for verifying the accuracy of provider information included in the directory at last every 90 days, and must have a process for removing a provider if the plan cannot verify provider or facility information.

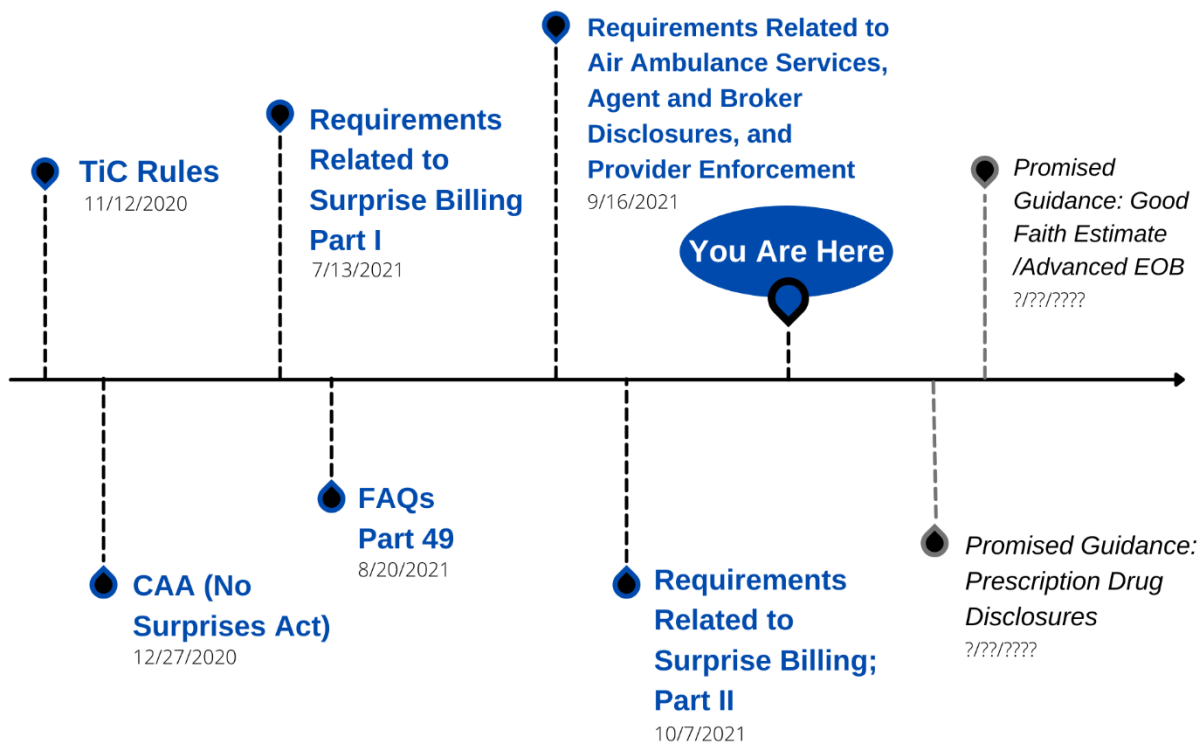
General CAA Provisions

- Broker Compensation Disclosures (*effective 12/27/2021*): Requires “covered service providers”, including brokers and consultants, to make disclosures to group health plan fiduciaries that include a description of the services provided and the fees collected in exchange for the services.
- Gag Clauses Prohibited (*effective 12/27/2020 – good faith compliance standard*): Prohibits group health plans from agreeing to restrictions in provider network contracts that would directly or indirectly prevent them from accessing certain cost and quality information and providing it to members. (The requirement for plans to attest to compliance is delayed until at least the 2022 plan year.)

- Pharmacy Disclosures* (*deferred enforcement pending additional rulemaking*): Group health plans must report to the Departments certain information regarding the cost and dispensing data for the prescription drug benefits offered under the plan. HHS will use the information to draft a non-plan-specific report that will be posted to the public portion of its website.
- Mental Health Parity NQTL Analysis (*effective 2/10/2021*): Plans must analyze their compliance with the nonquantitative treatment limitations (“NQTL”) requirements of the Mental Health Parity and Addiction Equity Act (“MHPAEA”) (*i.e.*, limits on benefits that are not tied to specific monetary or visit limits for mental health services) by completing a written comparative analysis that must be produced to state agencies, the DOL, and HHS upon request.

How We Got Here

Below is a timeline that retraces our steps to show how we arrived at the present state of the guidance:



- **11/12/2020** – Departments promulgate TiC rules based on authorizing language in the ACA.
- **12/27/2020** – No Surprises Act signed into law as part of the CAA.

- **7/13/2021** – Departments, in combination with OPM, publish [Requirements Related to Surprise Billing; Part I](#). This interim final rule implements certain provisions of the No Surprises Act intended to protect individuals covered by group health plans and group and individual health insurance coverage from surprise medical bills when they receive emergency services, non-emergency services from nonparticipating providers at participating facilities, and air ambulance services from nonparticipating providers of air ambulance services.
- **8/20/2021** - Departments publish ACA and CAA [FAQs Part 49](#), which provides additional guidance regarding enforcement of the TiC and CAA transparency provisions, delays effective dates for several TiC and CAA requirements, and establishes a “good faith, and reasonable interpretation” standard for other provisions. (This important guidance is reflected in the italicized text for each requirement described above.)
- **9/16/2021** – Departments publish [Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement](#) proposed rule. The proposed rule covers several areas, including requiring plans and providers to submit information to the Departments and OPM about air ambulance services, requiring issuers who offer certain insurance to disclose and report commissions to policyholders and HHS, and describing the process by which HHS would investigate and take enforcement action regarding potential violations of the Public Health Service Act.
- **10/7/2021** – Departments and OPM publish interim final rules titled [Requirements Related to Surprise Billing; Part II](#) that implement the independent dispute resolution (IDR) process described in the No Surprises Act to assist plans and providers in determining the out-of-network rate for certain items and services.

Our Most Recent Stop

The most recent guidance (the last store we visited) is the [Requirements Related to Surprise Billing; Part II](#), which provides additional information about the independent dispute resolution (IDR) process that will apply to surprise medical bills beginning on January 1, 2022.¹ Under the No Surprises Act, medical bills that arise from out-of-network emergency care, or services provided by out-of-network providers at an in-network facility or that are performed without a patient’s consent are considered surprise medical bills. For these surprise medical bills, patients will be required to pay only the in-network cost-sharing amount (which will be applied to the participant’s deductible and out-of-pocket maximums), and providers will not be able to “balance bill” for any remaining amount.

Under the No Surprises Act, a provider wishing to challenge the complete denial of payment for a surprise medical bill or initial amount paid by a plan for a surprise medical bill must initiate, in writing, an open negotiations period within 30 days of the denial or initial payment. If no agreement is reached regarding the payment amount during the 30-day open negotiation process, the out-of-network claim

¹ On October 25, 2021, CMS published notice of a website launched by the Departments and OPM that provides general information about the No Surprises Act and standard notice and consent document and a model disclosure form regarding balance billing. See <https://www.cms.gov/files/document/memo-no-surprises-act-phone-number-and-website-url-clean-508-mm2.pdf>.

may be submitted to arbitration, which may be initiated by the plan or the provider within four business days after the conclusion of the open negotiation process.

The No Surprises Act provides that the arbitration will be “baseball” style, meaning the parties will each present offers, and the arbitrator will pick one or the other (there is no negotiation regarding the amount or any ability to split the difference). According to the statute, the IDR arbitrator must presume that the “qualifying payment amount” (QPA) is the appropriate amount to be paid to the provider unless “additional circumstances” clearly demonstrate that the QPA is materially different from the appropriate out-of-network rate. The QPA represents the plan’s median in-network rate for the same or similar services, furnished in the same or a similar facility, located in the same or a similar geographic area, by a provider with the same or similar specialty. The “additional circumstances” that may be considered include the level of training and experience of provider, the “acuity” of the individual receiving the service and complexity of providing it, and good faith efforts of the provider and insurer in attempting to enter into network agreements. In making its determination, the IDR arbitrator is precluded from considering the provider’s billed charges, the “usual and customary charges,” or Medicare reimbursement rate.

The interim final rules reaffirm the QPA as the starting point for the IDR arbitrator’s analysis because the rules assert that the QPA represents reasonable, market-based payment for the items and services provided and confirm that the arbitrator must select the offer closest to the QPA unless additional information demonstrates the QPA is materially different from the appropriate out-of-network rate. The interim final rules clarify that the arbitrator must provide the rationale for its determination in a written decision that will be submitted to both parties, the Departments, and the OPM. If the arbitrator selects the offer that is not closest to the QPA, its rationale must describe the information the arbitrator relied on in determining that the QPA was materially different from the appropriate out-of-network rate. The interim final rule also states that multiple cases of a similar nature can be batched together for a single review and determination and confirms that the loser will be responsible for paying the costs of arbitration.

What Should We Do Now?

Group health plan sponsors should decide where to go next. Though it may be tempting to head for the parking lot (or self-soothe in the food court), group health plans ultimately will be responsible for ensuring compliance with many aspects of the above transparency requirements, even if they are almost completely dependent on their insurance carriers and third-party administrators (“TPAs”) to implement the requirements. Accordingly, group health plan sponsors should take the following actions:

- Complete (or cause to be completed) a written comparative analysis regarding the MHPAEA nonquantitative treatment limitations requirements, leveraging vendor resources and the [DOL’s Self-Compliance Tool for the MHPAEA](#) as necessary.
- Work with the plan’s insurance carrier / TPA to ensure insurance ID cards for the 2022 plan year are in good faith compliance with new disclosure requirements, and that the carriers and TPAs commit to updating provider directories.
- Review and amend, as necessary, vendor services agreements to remove any prohibited gag clauses that may prevent access to cost and quality information and the ability to share that

information with members. Prepare to attest that the agreements comply with this requirement, perhaps as soon as 2022.

- Identify and update all broker and consultant agreements to reflect the requirement that broker/consultant fees will be disclosed far enough in advance of the intended execution of an agreement for plan fiduciaries to act in accordance with their duties under ERISA regarding the selection of plan service providers.
- Discuss your carrier/TPA's plans for complying with various transparency requirements under the TiC and CAA (including the development of machine-readable public disclosures) and allocate responsibility for compliance. Review and amend, as necessary, vendor services agreements to reflect the carrier/TPA's agreed-to obligations. In addition, seek indemnification for penalties that may be assessed in the event of noncompliance.
- Update vendor services agreements to reference the IDR process for surprise medical bills and address additional expenses associated with IDR arbitration process and fees.
- Continue discussions with your carrier/TPA/pharmacy benefit manager regarding the production of machine-readable files relating to prescription drug pricing and prepare for reporting on pharmacy benefits and costs.
- Ensure that plan documents, certificate/evidence of coverage documents, and summary plan descriptions (SPDs) are timely updated to reflect material changes.

The guidance summarized above is incredibly detailed, complex, and evolving. Please do not hesitate to contact a member of [Verrill's Employee Benefits & Executive Compensation Group](#) if you have any questions.

Created by Verrill's Employee Benefits & Executive Compensation Group, November 2021. This blog is provided for general information only and may not be relied upon by any person as legal advice.