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POWER *through Partnership*

NEW AND UPCOMING COST TRANSPARENCY RULES

A myriad of rules aimed at improving health care price transparency have recently taken effect or are set to take effect very soon. These rules correspond to provisions found in the Consolidation Appropriations Act of 2020 (CAA) and the Affordable Care Act of 2010 (ACA). While the intent of these transparency measures is to drive competition and help consumers make more informed decisions about their care, implementation is going to be challenging, and in some cases, very technical and costly.

The following chart summarizes what's new and forthcoming in order of applicability date. In most circumstances, insurers, third-party administrators (TPAs), and pharmacy benefit managers (PBMs) are the only parties in a position to develop and implement the tools, services, and operational supports needed to satisfy the new transparency requirements. The CAA transparency mandates are subject to the same general enforcement structure as the earlier ACA plan design mandates (i.e., per participant monetary penalties, Department of Labor (DOL) enforcement actions and penalties, and participant lawsuits).

Accountability for any compliance failure is shared in general both by plan sponsors (regardless of whether the plan is fully-insured or self-insured) and insurers. Implementing regulations may contain relief or a safe harbor for fully insured plans (similar to the ACA final transparency rule). However, as noted below, the rulemaking process has yet to begin on many of the CAA mandates so the availability of any such relief is to be determined.

Transparency Rules: Implementation Timeline

Requirement	Details	Applicability Date	Rulemaking Status	Practical Note
No Gag Clauses	Group health plans* are prohibited from entering into contracts containing clauses that would restrict the plan sponsor from: • Offering provider-specific cost or quality of care information to the plan sponsor, providers, or participants • Accessing electronically de-identified claims and encounter data, upon request, and consistent with HIPAA, GINA, and ADA rules • Sharing this information with the plan's business associates Reasonable restrictions on public disclosure are permitted. Group health plans must submit annual attestations to the Department of Health and Human Services (HHS) stating that their plans comply with the requirements of the law.	12/27/2020 (date of enactment of the CAA)	TBD	Employers should ask their insurers, TPAs, and PBMs if their provider contracts contain any impermissible gag clauses.
Pharmacy Benefit Reporting	Group health plans* (excluding church plans) must annually report detailed information about the plan's prescription drug and total health care spend, including: • The plan year • The number of plan participants • A list of each state in which the plan is offered • The 50 brand prescription drugs most frequently prescribed, along with the total number of prescriptions filled for each • The 50 most expensive prescription drugs • The 50 prescription drugs that increased the most in cost relative to the prior year • Total spending on health care services broken down by type (e.g., hospital, primary care, specialists, prescription drugs) • Average monthly premium and the associated employer/employee contribution amounts • Impact on premiums by rebates, fees, and any other compensation paid by drug manufacturers to the plan or coverage or its administrators or service providers	First report due 12/27/2021 and by 6/1 each year thereafter	HHS, Treasury, and the DOL issued a RFI consisting of 41 questions on 6/23/2021; comments due by 7/23; rules to follow.	The data elements required to complete this reporting will need to come from multiple entities, including employers, insurers, TPAs, and PBMs.

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Requirement	**Details**	**Applicability Date**	**Rulemaking Status**	**Practical Note**
Mental health parity NQTL comparative analysis reporting	Group health plans subject to the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 must perform and document comparative analyses of the design and application of non-quantitative treatment limitations (NQTLs) on medical benefits and mental health/substance use disorder benefits. NQTLs are limits that are expressed non-numerically and include items like medical management techniques, provider network standards, and prescription drug formulary design.	2/10/2021; must be made available upon request	The DOL issued guidance on the NQTL comparative analysis requirement on 4/2/2021. The DOL has a self-compliance tool to assist plan sponsors and insurers in complying with the MHPAEA parity rules.	AssuredPartners is researching independent consulting solutions in anticipation that some reports prepared by insurers, TPAs, and PBMs will be insufficient.
Broker/consultant compensation disclosure	Brokers and consultants for ERISA-covered group health plans must provide advance written descriptions to plan fiduciaries about services to be performed and compensation they expect to receive; applies to amounts of $1,000 or more of direct or indirect compensation.	Contracts executed, extended, or renewed on/after 12/27/2021	Proposed rules expected 7/2021.	AssuredPartners is positioned to comply with this requirement.
Continuity of care	If a participant is receiving continued care for ongoing medical conditions from a specific in-network provider or facility and their network status changes, the participant can continue to receive care from the provider at the in-network cost sharing amount for up to 90 days. Group health plans* are responsible for notifying impacted participants of the change in network status and the right to continue care.	1/1/2022	TBD	Employers should ask their insurers, TPAs, and PBMs if they are prepared to notify participants when required.

Transparency Rules: Implementation Timeline

Requirement	Details	Applicability Date	Rulemaking Status	Practical Note
Surprise billing protections	Participants are protected from surprise medical bills for certain out-of-network care. Member cost sharing is capped at in-network cost sharing amounts for (1) out-of-network emergency care, (2) out-of-network non-emergency care provided at in-network facilities (subject to very limited exceptions), and (3) air ambulance services. Group health plans and non-participating providers may participate in direct negotiation and independent dispute resolution ("IDR") procedures to determine the amount that will be paid for a provided service.	Plan years beginning in 2022	HHS, Treasury, and the DOL issued an interim final rule and request for comments on 7/1/2021.	Many states have already passed laws preventing surprise medical billing, but they generally only apply to fully-insured plans. This new requirement applies to all group health plans (excluding account-based plans and plans consisting solely of "excepted benefits") regardless of funding arrangement.
Cost-sharing amounts on ID cards	Group health plans must list in-network and out-of-network deductibles and out-of-pocket maximums on ID cards.	Plan years beginning in 2022	TBD	Employers may need to pay for new ID cards if this information is not already printed on them. ID cards will also need to be reissued if deductible or OOP amounts change.
Advanced Explanation of Benefits (EOBs)	Group health plans must provide cost sharing estimates, provider network status, and any medical management requirements to enrollees upon receiving notice of scheduled services and good faith estimates of charges from provides or facilities. Enrollees may also request advanced EOBs for services they would like to schedule.	Plan years beginning in 2022	TBD	This will require coordination between the employer's claim and network administrator(s) and the participant's care providers. Employers should inquire with their insurers/TPAs as to their readiness to comply with this requirement.

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Price comparison tool	Group health plans* must offer price comparison guidance by telephone and provide a website tool that allows enrollees to compare patient-specific cost sharing information for in-network services. A similar but separate requirement under the ACA's Transparency in Coverage final rule takes effect in 2023 (see bottom of this chart).	Plan years beginning in 2022	TBD	Employers should inquire with their insurers/TPAs as to their readiness to comply with this requirement. Employers may be asked to pay a share of the cost to develop and maintain this tool. Employers may want to confirm whether any records will be maintained for participant inquiries (either online or by phone), and if so which.
Accuracy of provider directories	Group health plans* must establish provider databases on public websites and verify accuracy of information every 90 days. Updates must be made within two days of notification of a change by a provider or facility. If a plan participant receives incorrect information, they will only be responsible for the in-network cost sharing amount.	Plan years beginning in 2022	TBD	Employers should seek confirmation from their insurers, TPAs, and PBMs that provider directory information is accurate and updated in a timely manner.

Transparency Rules: Implementation Timeline				
Requirement	**Details**	**Applicability Date**	**Rulemaking Status**	**Practical Note**
Transparency in coverage	Non-grandfathered group health plans must disclose price, cost sharing, and out-of-pocket expense information using standardized formats to allow easy cost comparisons. Specifically: • Public website disclosure (and monthly updating) of in-network medical and pharmacy rates and out-of-network allowed amounts, i.e., online posting of machine-readable files (2022) • Self-service online tool providing personalized cost sharing information for 500 "shoppable service" items (i.e., that can be scheduled in advance by a healthcare consumer), as well as cost sharing liability estimates and other disclosures (2023) • Pricing information for all items and services (2024) Fully insured plan sponsors are deemed to satisfy these rules if their insurers are required to provide the required information pursuant to written agreements.	Implementation occurring in phases starting with plan years beginning in 2022	HHS, Treasury, DOL issued a final rule implementing these requirements on 11/12/2020.	Employers may be asked to pay a share of the cost to develop and maintain these tools.
***It is uncertain whether this requirement applies to all group health plans or only to non-grandfathered plans.**				