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Legislative Update

SUMMARY OF TRANSPARENCY COMPLIANCE REQUIREMENTS

Several pieces of federal legislation have recently been enacted to improve pricing and coverage transparency in group and individual markets. The following is a high-level summary of the No Surprises Act and the Transparency of Coverage provisions contained in the Consolidated Appropriations Act, 2021 (CAA).

NO SURPRISES ACT

The No Surprises Act becomes effective January 1, 2022 and applies to both grandfathered and non-grandfathered plans. However, it does not apply to excepted benefits, health reimbursement accounts, and stand-alone retiree plans. Included are the following consumer protections and transparency requirements:

- Balance billing protections and out-of-network cost sharing prohibitions for emergency services, certain non-emergency services, and air ambulance;
- New external review requirements;
- Continuity of Care requirements;
- Provider directory requirements;
- Advance explanation of benefits (EOB) and price comparison tools;
- ID Card information; and
- Patient protections regarding primary care physician designations

To implement the provisions of the No Surprises Act, to date three interim final rulings have been issued. An interim final rule was issued on July 1, 2021 that addressed restrictions on surprise billing for patients in job-based and individual health plans who get emergency care or non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. Then on September 30, 2021, a second interim final rule to provide additional protections, and on November 17, 2021, a third interim final rule was issued that would implement new requirements for group health plans and issuers to submit certain information about prescription drug and health care spending.

Various CMS Model Notices and Information requirements can be found here. For additional information, please visit the CMS website at https://www.cms.gov/nosurprises.

TRANSPARENCY RULE FOR HEALTH PLANS AND PROVIDERS

The Transparency in Coverage Rule applies to non-grandfathered insured and self-insured group health plans. For plan years beginning on or after January 1, 2022, group health plan sponsors and issuers will be required to disclose the price and cost-sharing information to participants, beneficiaries, and enrollees upon request. Plans and issuers will also be required to disclose on a public website their in-network negotiated rates, billed charges and historical allowed amounts paid to out-of-network providers, and the negotiated rate and historical net price for prescription drugs. Personalized

cost-sharing information must also 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 January 1, 2023. The remainder of all items and services will be required for plan years beginning on or after January 1, 2024. The final rule also allows issuers that share savings with consumers resulting from consumers shopping for lower-cost, higher-value services, to take credit for those "shared savings" payments in their medical loss ratio (MLR) calculations.

With respect to the requirements set to take effect on January 1, 2022, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) have indicated it will defer enforcement of several provisions, including the rules regarding:

- Publishing transparency in coverage machine-readable files related to prescription drug pricing (pending further rulemaking);
- Publishing other types of machine-readable files (until July 1, 2022);
- Providing a price comparison tool (until January 1, 2023);
- Providing a good faith estimate of expected charges and Advanced Explanation of Benefits to certain individuals (pending further rulemaking); and
- Reporting of pharmacy benefit and drug costs (pending further rulemaking).

NEXT STEPS

To comply with the No Surprises Act, plan sponsors of self-funded medical plans and health care insurers are required to make certain information publicly available and post it on their public website, as well as include it on their EOB forms (when applicable) effective with plan years beginning on or after January 1, 2022. A model disclosure notice is available here.

The Departments plan to issue regulations on the interaction of the CAA and the transparency in coverage final rules as well as rules with respect to the No Surprises Act provider directory and continuity of care requirements. Regulations may not be issued until after January 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. Likewise, good faith, reasonable interpretations of the statutory requirements should be used to comply.

The Departments also provided an example of a plan or insurance identification card that would be compliant with the transparency requirements for those cards under the No Surprises Act.