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Are We There Yet? CAA and Transparency in Coverage

The Consolidated Appropriations Act (CAA) and Transparency in Coverage (TiC) Rule comprise the most comprehensive legislative and regulatory reforms facing group health plans since the Affordable Care Act.

As the year is already more than half over, plan sponsors cannot help but ask, “Are we there yet?” While we are not there quite yet, group health plans should have made considerable progress in complying with the various CAA and TiC requirements by now.

Below, we provide a summary of the various requirements and reminders about where group health plans should be in terms of compliance to date.

Requirements Effective for Plan Years Beginning On or After January 1, 2022

Machine Readable Files – delayed enforcement date: July 1, 2022

Note that this requirement applies only to non-grandfathered plans. Calendar-year plans as well as plans with plan years beginning on or before July 1, 2022 should have, by July 1, posted to their public websites, machine-readable files (MRFs) containing:

- Network rates (negotiated in-network rates for all covered items/services); and
- Out-of-network amounts (historical allowed amounts including billed charges and payments for out-of-network providers).

Plans with plan years beginning after July 1, 2022 should post these MRFs in the month in which the 2022 plan year begins.

Plans should work closely with their medical claims payers to ensure the MRFs are in the correct format and posted to a public website without requiring credentials for

an individual to access the MRFs.

A third MRF requirement for prescription drug prices (in-network rates and historical prices for all covered prescription drugs) is currently delayed pending further rulemaking.

No Surprises Act Claims

The No Surprises Act (NSA) requires many changes to the administration of certain out-of-network claims, including the payment of such claims as in-network (NSA claims). By the first day of the 2022 plan year, plans must pay NSA claims using a median in-network contract rate for the specific geographic region (qualifying payment amount or QPA).

Non-network providers generally cannot balance bill patients for these types of claims. Specific notice and written consent rules apply before non-network providers can balance-bill for post-stabilization services and certain other non-network services at network facilities.

Plans and providers must resolve QPA payment disputes through an Independent Dispute Resolution (IDR) process.

Participants may seek external review of denied NSA claims under the plan claims and appeal procedures.

NSA claims include the following:

- Emergency and post-stabilization services (facility and professional fees at hospitals and urgent care centers licensed to provide emergency services);
- Air ambulance services;
- Certain non-network services incurred at a network facility (hospital, outpatient department, surgical center) including:
    - Anesthesiology, pathology, radiology, neonatology;
    - Assistant surgeons, hospitalists, intensivists;
    - Diagnostics, radiology, laboratory services; and
    - Other services provided by a non-network provider when no network provider is available.

By the first day of the 2022 plan year, plan sponsors and claims payers should:

- Ensure their claims administration systems are programmed to properly pay NSA claims;
- Post the Surprise Billing Notice to their websites and include the disclosure with Explanations of Benefits for NSA claims;
- Amend plan documents to provide for the NSA claims payment rules and external review, as well as defined terms such as Qualifying Payment Amount, Emergency and Post-Stabilization Services, etc.

Network Provider Directory

As of the first day of the 2022 plan year, plans must provide accurate online network provider directories with regular updates at least every 90 days. Plan administrators must respond to a participant's request for a directory within one day and must retain records of such communication for a minimum of two years.

If a participant relies upon inaccurate directory information with respect to a provider's network status, the plan must process related claims as in-network claims for purposes of participant cost-sharing.

To ensure compliance with this requirement, plan administrators should be in regular communication with their network administrator to ensure the network directory remains current. To the extent practicable, plan sponsors might also consider adding provisions to their network administration agreement to ensure that the network administrator will make the plan whole for any costs incurred due to directory errors. While this requirement is subject to a good faith reasonable interpretation of the statute pending further guidance, plan sponsors may consider amending their plan documents to align with the network provider directory rule.

Continuity of Care

Effective with the 2022 plan year, when a participant is receiving certain types of care from a provider who leaves the plan's network, the plan is required to offer continuity of care coverage. Such coverage allows the participant to continue treatment with the provider at the network level for up to 90 days in the following situations:

- Serious and complex conditions;
- Terminal illness;
- Institutional or inpatient care;
- Scheduled non-elective surgery and post-operative care; and

Along with ensuring that their claims payers are properly administering NSA claims, plan administrators should develop a process to identify and notify continuing care patients of their coverage options. Plan sponsors should amend their plan documents to provide for the continuity of care coverage provisions.

ID Cards

Effective with the 2022 plan year, ID cards provided to participants must now include the following information in a clear manner:

- Deductibles (both in-network and non-network);
- Out-of-Pocket Maximums (both in-network and non-network);
- Phone number for assistance; and
- Website for assistance.

Plan sponsors should ensure that their administrators have updated participant ID cards to reflect the required information, both in hard-copy and electronic versions, and be able to demonstrate that their efforts meet the good faith standard required until further guidance is issued.

Previous Requirements

The following requirements were initially effective last year, with ongoing effect.

Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis – February 10, 2021

The CAA requires plans to perform and document comparative analyses of NQTLS to demonstrate compliance with mental health parity requirements (e.g. precertification, step therapy, etc.). Such analyses must be made available to the DOL (or other applicable entity) upon request.

ERISA 408(b)(2) Disclosures – December 27, 2021

Plans must receive compensation disclosures from their service providers (including brokers and consultants), for all agreements (new or renewed) entered into on or after December 27, 2021.

Removal of Gag Clauses – December 27, 2020

Plans must ensure that their contracts with third-party administrators and/or entities that provide access to provider networks do not restrict the plan from disclosing certain provider specific costs or quality of care information. Plans will also eventually have to submit attestation of compliance with this requirement to regulators (see delayed requirements below).

Delayed Requirements

The following requirements are effective after the 2022 plan year, or enforcement is currently delayed pending rulemaking by the government. We will publish additional details on these requirements as guidance is issued.

- Attestation of Prohibition on Gag Clauses – Attestation dates unknown
- Plan Cost/Spend Reporting – Enforcement date unknown, but anticipated reporting date is December 27, 2022
- Advanced Explanation of Benefits – Enforcement date unknown
- Air Ambulance Reporting – March 31, 2023 and March 31, 2024
- Price Comparison/Cost Estimate Tool – January 1, 2023 and January 1, 2024

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