October 2024
Employee Benefits Compliance

# Transparency Deadlines and Compliance Checklist

Over the past few years "transparency" has come to the forefront of group health plan compliance. This focus started with the Final Rule on transparency from late 2021, after which the Consolidated Appropriations Act ("CAA") of 2021 added more transparency requirements to bolster the Final Rule requirements. In addition, new Broker Disclosure rules from the CAA brought to light how transparency rules also impact existing ERISA fiduciary duties. These are two sets of complex rules (transparency and fiduciary duties) that employer plan sponsors will need to better understand. For a comprehensive review of transparency, see our webinar Seeing Through Transparency: How the New Requirements Impact Group Health Plans or review our Alliant Insight - Transparency Rules and Surprise Billing Protections. For a better understanding of ERISA Fiduciary rules see our webinar Employer ERISA Fiduciary Duties in the New Era of Transparency or review our Alliant Insight - ERISA Fiduciary Duties The Impact of Transparency and How to Protect Your Plan. The most important employer plan sponsor obligation with respect to both transparency and fiduciary duties is largely selecting the right partners to facilitate and support compliance with transparency rules, which in turn supports the employer plan sponsor in meeting its fiduciary obligations. Importantly, employers cannot comply with transparency rules without carrier and TPA support because employers generally do not have the required information or systems. This Transparency Deadlines and Compliance Checklist is designed to assist employer plan sponsors understand where their plan partners are in this process.

## Transparency in Coverage (TiC) Final Rules

(Does not apply to grandfathered plans, excepted benefits, or account based plans. Does apply to all other group health plans, including church plans and non-federal governmental plans, as well as prescription drug plans.)

| Rule | Requirement | Original Deadline | New Deadline | Compliance |
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| External Disclosure | Requires carriers and group health plans to post 3 machine readable files on a public website: (1) all in-network rates for covered items and services, (2) out-of-network allowed amounts and billed charges for covered items and services, (3) all in-network negotiated rates and historical prices for prescription drugs (Rx component delayed)[1]<br><br>Where a group health plan does not maintain a public website (most do not) the plan can satisfy posting requirements by entering into a written agreement where the plan's insurance insurer or TPA posts the required information on its public website. | Plan years beginning on or after January 1, 2022 | **Delayed.** Requirements regarding the first two files will not be enforced until **July 1, 2022.** On July 1, 2022, the departments will enforce the requirement to post files for plan years beginning on or after January 1, 2022. For plan years beginning after July 1, 2022, plans must post files in the month in which the plan year begin.<br><br>**Prescription drug component was initially delayed** but, on **September 27th, 2023**, the departments announced an end to the period of enforcement discretion for this component as well. | ☐ Carrier/TPA in Compliance<br>☐ Compliance Underway<br>☐ Compliance Concern |
| Internal Price Comparison | Requires carriers and group health plans to make price comparison | Cost-sharing information | **No delay. Plan years beginning on or after January 1, 2023** with phased in | ☐ Carrier/TPA in Compliance |

[1] In addition, the Pharmaceutical Care Management Association (PCMA) has filed suit challenging the pharmacy component of the machine-readable file transparency requirement, alleging that the rule violates the Administrative Procedure Act (APA) and is inconsistent with the Affordable Care Act (ACA). This case is pending in the federal district court in the District of Columbia.

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| Tool (note that the CAA contained a similar requirement that is considered duplicative so will be encompassed by Final Rule requirements) | information available to participants, through an internet-based self-service tool and in paper form, upon request. | must be available for 500 listed items and services for plan years beginning on or after January 1, 2023 with information for all items and services available for plan years beginning on or after January 1, 2024. | compliance for **plan years beginning on or after January 1, 2024**.<br>Incorporation of the CAA provisions and further rulemaking may extend this requirement to grandfathered plans. | ☐ Compliance Underway<br>☐ Compliance Concern |

## Consolidated Appropriations Act of 2021

(Does not apply to excepted benefits or account based plans. Does apply to all other group health plans, including grandfathered plans, church plans and non-federal governmental plans, as well as prescription drug plans.)

| Rule | Requirement | Original Deadline | New Deadline | Compliance |
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| Plan Identification Cards | Requires carriers and group health plans to include in clear writing, on any physical or electronic plan or ID card issued to participants, any applicable deductibles, any applicable out-of-pocket maximum | Plan years beginning on or after January 1, 2022. | **No delay.** Plans are expected to implement the ID card requirements using a good faith interpretation of the law for **plan years beginning on or after January 1, 2022.** | ☐ Carrier/TPA in Compliance<br>☐ Compliance Underway |

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| | limitations, and a telephone number and website address for individuals to seek consumer assistance. | | | ☐ Compliance Concern |
| Advanced Explanation of Benefits | Requires carriers and group health plans, upon receiving a "good faith estimate" regarding an item or service, to send a participant, (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) an Advanced Explanation of Benefits notification in clear and understandable language. | Plan years beginning on or after January 1, 2022. | **Delayed** pending further rulemaking. | ☐ Carrier/TPA in Compliance<br>☐ Compliance Underway<br>☐ Compliance Concern |
| Prohibition on Gag Clauses on Price and Quality Data | Prohibits carriers and group health plans from entering into an agreement with a provider, network or association of providers, TPA, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from three specific items.<br>Requires annual compliance attestation to CMS by December 31. Insurance issuers, PMBs, and TPAs can submit the required attestation on behalf of a plan by entering into a written agreement with the employer plan sponsor. | December 27, 2020 (the date of enactment of the CAA). | **No delay. December 27, 2020.**<br>Attestation due annually to CMS by December 31 each year beginning on **December 31, 2023**. | ☐ Carrier/TPA in Compliance<br>☐ Compliance Underway<br>☐ Compliance Concern |

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| | Review contracts with TPAs and other entities that provide access to a network of providers to eliminate gag clauses. Enter agreements with partners to submit required attestation on behalf of the plan. | | | |
| Protecting Patients and Improving the Accuracy of Provider Directory Information | Requires insurers and group health plans to publish on a public website a provider directory that is updated at least every 90 days and respond to participant questions within one business day. Insurers and group health plans must also provide information about the federal and applicable state law prohibitions and rules on balance billing, as well as contact information for appropriate state and federal agencies to report any issues.<br><br>Where a group health plan does not maintain a public website (most do not) the plan can satisfy posting requirements by entering into a written agreement where the plan's insurance insurer or TPA posts the required information on its public website.<br><br>If an individual receives an item or service by a nonparticipating provider or at a nonparticipating facility, and was provided inaccurate information via the | Plan years beginning on or after January 1, 2022 | **No delay. Plan years beginning on or after January 1, 2022.** Plans and issuers are expected to implement these provisions using a good faith, reasonable interpretation of the statute. | ☐ Carrier/TPA in Compliance<br><br>☐ Compliance Underway<br><br>☐ Compliance Concern |

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| | provider directory, the plan must cover the service at the in-network rate. | | | |
| Continuity of Care | Requires insurers and group health plans to provide notice of the right to continuing care and to provide such care when treatment is disrupted as a result of contractual changes that impact participant access to or payment for certain providers and facilities.<br><br>On request, the plan must permit continued care under the same terms and conditions as would have applied had the changes to the plan's network not occurred through the earlier of 90 days beginning on the date the required notice was provided or until the individual is no longer a continuing care patient. | Plan years beginning on or after January 1, 2022. | **No delay. Plan years beginning on or after January 1, 2022.** Plans and issuers are expected to implement the requirements using a good faith, reasonable interpretation of the statute. | ☐ Carrier/TPA in Compliance<br>☐ Compliance Underway<br>☐ Compliance Concern |
| Reporting on Pharmacy Benefits and Drug Costs | Requires insurers and group health plans to submit detailed data on their plans, locations, health care spending, prescription drug benefits, and any rebates. Implementing regulations require most data elements be aggregated (rather than plan specific) and ultimately submitted by carriers, TPAs and PBMs. | December 27, 2021. Annual reporting, then required by June 1 of each year. | **Delayed.** Plans should start working to ensure that they can report the required information with respect to 2020 and 2021 data by **December 27, 2022.** | ☐ Carrier/TPA/PBM in Compliance<br>☐ Compliance Underway<br>☐ Compliance Concern |

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| Broker & Consultant Compensation Disclosure **(Does not apply to non-ERISA plans)** | Requires certain "covered service providers" (CSP) provide written information about their fees (including all direct and indirect compensation) and services to employer plan sponsors to ensure compensation is reasonable. Disclosure is required in advance of entering into an agreement, on request, and within 60-days of any change to compensation. A failure to disclose creates an ERISA prohibited transaction. | Contracts entered into, extended or renewed on or after January 1, 2022 | **No Delay.** Contracts entered into, extended or renewed on or after **January 1, 2022.** | ☐ Consultant in Compliance<br>☐ Compliance Underway<br>☐ Compliance Concern |

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