March 2023 Employee Benefits Compliance

Transparency Rules and Surprise Billing Protections

Introduction

Recent federal legislation has included transparency provisions that apply to most group health plans as well as new protections against surprise billing. Although most of these rules were part of the Consolidated Appropriations Act of 2021 (the CAA), they build on and overlap with prior transparency rules issued by the Department of Labor (DOL), Health and Human Services (HHS) and Treasury (the Departments) as well as significant state and federal efforts to curb surprise billing**. For practical purposes, compliance with these requirements will fall to insurers and third party administrators (TPAs) by contract, but employers sponsoring self-funded plans are ultimately responsible** for compliance and will need to make sure that TPAs and other partners can implement and administer these new rules. A summary of and timeline for these rules is provided below, with jump links to specific topics. This Alliant Insight has been updated to reflect recently announced enforcement delays.

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Final Transparency Regulations

On October 29, 2020, the Departments issued their final rule on transparency in health plan coverage. The final transparency rule complements a similar hospital transparency rule issued by HHS that requires hospitals to post standard charge information based on negotiated rates for common items or services effective on January 1, 2021 (recently upheld by the D.C. Circuit Court of Appeals). The final rule on transparency in health plan coverage generally has two parts. Insurers and non-grandfathered group health plans must:

1. Provide cost-sharing information to enrolled individuals through an online tool on their website and in paper form. As discussed below, this part of the rule will be phased in for plan years beginning in 2023 and is fully effective in 2024.
2. Publicly disclose pricing information in three machine-readable files for: (1) rates for in-network providers, (2) billed charges and allowed amounts for out-of-network providers, and (3) in-network prices for prescription drugs. This part of the rule will go into effect for plan years beginning in 2022.

The final rule does not apply to grandfathered plans, excepted benefits, or account based plans like HRAs or H-FSAs. It does apply to all other group health plans, including church plans and non-federal governmental plans, as well as prescription drug plans.

Disclosure of Cost-Sharing Information to Enrollees on Request for Price Comparison

Upon request, plans and insurers must disclose to current plan participants and beneficiaries (enrollees) estimates of cost-sharing for covered health care items and services from a particular provider. Items or services include encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees (including facility fees). The goal is to enable enrollees (or their representatives), to obtain an estimate of out-of-pocket expenses in advance. As noted above, this disclosure requirement will be phased in, and cost-sharing information 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**. The Departments identify the 500 items and services (along with a plain language description and CPT code) in the preamble of the final rule. This disclosure is based on the structure of current explanation of benefits (EOB) notices. EOBs disclose a wide array of information including the amount billed, the in-network negotiated rate, allowed amounts for out-of-network providers, and the individual's cost-sharing obligations. But unlike EOBs, which are provided to patients after services have been delivered, this advanced disclosure should help enrollees choose more cost effective options. The Departments acknowledge cost-sharing data will only be an estimate and will not necessarily reflect the amount that a patient is ultimately charged.

Note that an additional requirement to make information available by telephone required by the CAA will be incorporated here in subsequent rulemaking.

Required Disclosure Content

The final rule outlines seven content elements that a plan or insurer must disclose, upon request, to an individual.

1. *Estimated Cost Share Liability.* This is an estimate of the amount that the individual would be responsible for paying under the plan's specific deductible, coinsurance, and copay structure. The estimated liability must be based on actual rates, allowed amounts, and individual-specific cost-sharing limits. It should also reflect any cost-sharing reductions. This estimate does not include premiums, balance billing amounts for out-of-network providers, or the cost of non-covered items or services.
2. *Accumulated Amounts*. This is the amount of cost-sharing that the individual (or family) has already paid towards the plan's deductible or out-of-pocket maximum. The accumulated amount should also reflect any progress towards reaching a treatment limit (such as providing cost-sharing information based on the number of physical therapy visits already used relative to the plan's cap on the number of visits for physical therapy that could be covered).
3. *In-Network Rates*. Where plans have specifically negotiated contract rates with specific providers those must be disclosed (note that balance billing is generally not permitted in-network). The

Departments will require the disclosure of an in-network rate even if that rate does not impact the individual's cost-sharing liability. If the plan or insurer has no contractually agreed to rates or underlying fee schedule rates, it does not technically have a network and this element does not apply. If a plan has specifically negotiated an in-network rate with a provider as a percentage of Medicare or other formula the plan must disclose rates and fee schedules that result from such a formula as a specific dollar amount. With respect to prescription drug plans, cost sharing estimates provided through a standalone tool offered by a PBM or TPA will satisfy this element.

4. *Out-of-Network Allowed Amounts*. This is the allowed amount that a plan or insurer would pay for a covered item or service furnished by an out-of-network provider or any other calculation that provides a *more accurate* estimate of the amount the plan would pay (such as usual, customary, and reasonable rates). Again, this does not include balance billing amounts but if a plan uses a percentage of Medicare or other fixed formula the plan must disclose rates and fee schedules that result from such a formula as a specific dollar amount. A percentage can be disclosed instead of a dollar amount only if a plan reimburses out-of-network providers a percentage of *billed* charges.
5. *Items and Services Content List for a Bundled Payment*. This is a list of all covered items and services reflected in the cost-sharing estimate for a bundled payment arrangement. Plans and insurers do not have to list cost-sharing information separately for each covered item or service in the bundle.
6. *Notice of any Prerequisites to Coverage*. Plans and insurers must inform individuals that they may need to satisfy certain medical management techniques before the item or service will be covered. This list is limited to concurrent review, prior authorization, and step-therapy or fail-first protocols.
7. *Disclosure Notice*. This is a plain language notice that must include specific disclosures to inform individuals: (1) about the possibility of out-of-network balance billing that is not reflected in the cost-sharing estimate, (2) that actual cost-sharing may differ from the estimate, (3) that a cost-sharing estimate is not a guarantee of coverage, (4) whether copay assistance and other third-party payments count towards cost-sharing limits, and (5) that a recommended preventive service may be subject to cost-sharing if not billed as a preventive item or service. The balance billing statement is only required if balance billing is permitted under state law (balance billing is banned under some state insurance codes but this will be required for self-funded plans that cover out-of-network care). The final rule provides model language.

Methods of Disclosure

Plans and insurers will be required to disclose real-time cost-sharing estimates through a user-friendly online self-service tool and on paper. The online self-service tool must allow users to search for cost-sharing information for a covered item or service provided by a specific in-network provider or by all in-network providers by inputting: (1) a billing code (such as CPT[1] code 87804) or a descriptive term (such as "rapid flu test"), at the option of the user, (2) the name of the in-network provider, if the user seeks cost-sharing information with respect to a specific in-network provider, and (3) other factors utilized by the plan or insurer that are relevant for determining the applicable cost-sharing information (such as location of service, facility name, or dosage). It must allow users to search for an out-of-network allowed amount, percentage of billed charges, or other rate that provides a reasonably accurate estimate of the amount a plan or insurer will pay for a covered item or service provided by out-of-network providers by inputting: (1) a billing code or descriptive term, at the option of the user, and (2) other factors utilized by the plan or insurer that are relevant for determining the applicable out-of-network allowed amount or other rate

[1] Current Procedural Terminology.

(such as the location in which the covered item or service will be sought or provided). Lastly, the tool must allow users to refine and reorder search results based on geographic proximity of in-network providers, and the amount of the participant's or beneficiary's estimated cost-sharing for the covered item or service.

With respect to paper disclosures, all of the same information must be made available in plain language, without a fee, in paper form at the request of the enrollee. In responding to such a request, the plan or insurer can limit the number of providers to no fewer than 20 per request. The plan or insurer is required to: (1) disclose the applicable provider-per-request limit to the participant or beneficiary, (2) provide the cost-sharing information in paper form pursuant to the individual's request, and (3) mail the cost-sharing information in paper form no later than 2 business days after an individual's request is received.

Public Disclosures of In-Network Rates and Out-of-Network Allowed Amounts

In addition to individual enrollee disclosures, **effective July 1, 2022[2]** (original effective date was plan years beginning on or after January 1, 2022) plans and insurers must publicly post three machine-readable files: (1) a file on all in-network rates (including negotiated rates, underlying fee schedules, or derived amounts) with in-network providers for all covered items and services, (2) a file on out-of-network allowed amounts and billed charges for covered items and services provided by out-of-network providers, and (3) a file on in-network negotiated rates and historical prices for prescription drugs (as noted below, machine readable file requirements for prescription drugs are delayed pending additional guidance). The rule further identifies specific requirements for each file, summarized below. Information must be updated monthly and made publicly available on an insurer's or group health plan's website free of charge, without having to log-in or otherwise submit identifying information. 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. This data is intended to allow employers to negotiate better pricing but could also be used by out-of-network providers to better understand what percentage of a billed amount they are likely to receive. All three machine-readable files must be made available beginning in 2022. Payers and provider will need to amend contracts that include gag clauses or non-disclosure agreements in advance of this deadline.

In-Network Rates. Where plans have contracts with providers creating in-network negotiated rates and reimbursements several data elements are required. First, plans and insurers must include their Health Insurance Oversight System ID (preferably at the 14-digit product level). If a plan or insurer does not have a HIOS ID, it must use the employer's EIN. Next, specific billing codes (generally CPT, HCPCS, DRG, or NDC coding)[3], with which providers, insurers and TPAs are all readily familiar. Lastly, all applicable rates and fee schedules must be reflected as dollar amounts for each covered item or service associated with every provider identified by their National Identifier and Place of Service Codes. This file would only include reference based pricing arrangements with a defined network (contracted providers accepting a specific rate or reimbursement that will not result in balance billing).

Out-of-Network Billed and Allowed Amounts. Where plans cover items or services by providers without existing contractually agreed to rates, additional disclosures are required to reflect possible balance billing. As with the in-network file, this file must also include the plan's HIOS ID (preferably at the 14-digit product level) or the employer's EIN. Specific billing codes are also required and every provider must be

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[2] Requirements regarding the first two files will not be enforced by the Departments 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.

[3] Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code, National Drug Code (NDC).

identified by their National Identifier and Place of Service Codes. The additional disclosure required for the out-of-network file is historical data on billed charges and specific allowed amounts (the discrepancy is generally balance billed). The disclosure is specifically allowed amounts and billed charges covered for items or services furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date of the file.[4] All of a plan's allowed amounts must be reflected as actual dollar amounts (not as a percentage of either Medicare or an amount billed) to allow a direct comparison with a provider's billed amounts.

In-Network Prescription Drugs **(delayed pending additional guidance)**. Where plans cover prescription drugs a separate file is required for negotiated rates for prescription drugs. As with both files above, this file must include the plan's HIOS ID or employer's EIN and the National Identifier and Place of Service Codes for each in network provider. However, only the NDC specified by the Food and Drug Administration is needed to identify a specific drug. All negotiated rates must be reflected as actual dollar amounts associated with each pharmacy or network provider. Like the file for out-of-network historical data, this file also requires historical data during the 90-day time period that begins 180 days prior to the publication date of the file that applies to each NDC. However, historical data here is to account for rebates, discounts and charge backs as opposed to balance billing.

Transparency Rules under the CAA

As noted above, the CAA built on the final transparency rule by adding additional cost transparency provisions and requiring significant disclosures to participants. These provisions are effective for **plan years beginning on or after January 1, 2022**. Recent guidance confirmed that grandfathered health plans are generally subject to the requirements under the CAA. None of the requirements appear to apply to excepted benefits, or account based plans like HRAs or H-FSAs. They do apply to church plans and non-federal governmental plans, as well as prescription drug plans.

In and Out of Network Deductibles and Out-of-Pocket Information on ID Cards (No Delay – Good Faith Compliance)

The CAA requires group health plans to provide, in clear writing, on any physical or electronic plan or insurance identification card the following information: (1) any deductible applicable to the plan, (2) any out-of-pocket maximum limitation applicable to the plan, and (3) a telephone number and website where the participant may seek consumer assistance information. The requirement to provide information on the ID card regarding "any" deductible or out-of-pocket limit includes both in-network and out-of-network deductibles and out-of-pocket limits. This requirement applies to grandfathered plans.

Advanced Explanation of Benefits (Delayed Pending Additional Guidance)

Next, the CAA requires group health plans to provide to participants or providers an advance explanation of benefits with cost estimates within one business day of a request, or within three business days if a service is scheduled at least 10 business days out, that includes the following information:

- Whether or not the provider or facility is a participating provider or facility for the plan with respect to furnishing the item or service,
- A participating provider's contracted rate,

[4] Plans and insurers may omit data in relation to a particular item or service and provider when the report of out-of-network allowed amounts would be for fewer than 20 different claims for payments under a single plan.

- For a non-participating provider, information on how to obtain in-network provider access,
- A good faith estimate from the provider,
- A good faith estimate of the plan's coverage amount, the member's cost-sharing, and any deductible and out-of-pocket requirements already met as of the date of the notice,
- Explanation of any applicable medical management techniques,
- A disclaimer that it is a good faith estimate on items/services reasonably expected to be furnished and subject to change, and
- Any other valid disclaimers/information the plan deems appropriate to disclose.

Price Comparison Tool Requirement (Delayed as Duplicative of Final Transparency Rule)

In addition to the disclosures described above, group health plans must also offer price comparison guidance by telephone and make available on their websites a price comparison tool that allows participants to compare the amount of cost-sharing for certain items and services among different providers. Note that this requirements is similar to the cost-sharing disclosure under the final rule. Future guidance is expected to address how these two requirements relate to each other and in what cases compliance with one requirement will be deemed to be compliance with both requirements.

Regulators have indicated that this provision of the CAA is largely duplicative of requirements under the final transparency rule and that they are seeking comment on whether compliance with the final rule satisfies this provision of the CAA. However the requirement to also make information available by telephone would need to be incorporated into the Final Rule.

Provider Directory Information (No Delay – Good Faith Compliance)

In order to ensure participants have up to date information on available in-network providers and facilities, the CAA requires that group health plans maintain and provide current information on their provider network. Specifically, group health plans must establish a process to verify provider directory information at least every 90 days and respond to participant questions within one business day. 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. This information must be available on a public website. Notably, a participant who relies on a group health plan's inaccurate provider directory will be responsible only for the in-network cost-sharing amount if they provide documentation they received incorrect information, with the plan being responsible for the balance.

Continuity of Care (No Delay – Good Faith Compliance)

Where a group health plan's provider and/or facility network is disrupted as a result of contractual changes that impact participant access to or payment for certain providers and facilities, the group health plan is required to provide notice to each individual who is receiving "continuing care" from impacted providers and/or facilities of their right to elect transitional care with those providers or at those facilities. The notice must provide the individual the opportunity to notify the plan of the need for transitional care and the plan must then permit continued care under the same terms and conditions as would have applied had the changes to the plan's network not occurred. Care will end on the earlier of 90 days beginning on the date the above referenced notice was provided or until the individual is no longer a continuing care patient. A continuing care patient is defined as one who is: (1) undergoing a course of treatment for a serious and complex condition, (2) undergoing a course of institutional or inpatient care from the provider or facility, (3) scheduled to undergo non-elective surgery from the provide or facility, (4)

pregnant and undergoing a course of treatment for the pregnancy, or (5) determined to be terminally ill and receiving treatment for such illness from such provider or facility.

Reporting on Pharmacy Benefits and Drug Costs (No Delay)

The CAA also included specific pharmacy benefit and drug cost reporting requirements. All group health plans were required to submit detailed information to CMS initially by December 27, 2021, with annual reporting then required by June 1 of each year. The Interim Final Rule on Prescription Drug and Healthcare Spending clarified that carriers, TPAs and PBMs will report most of the information requested on behalf of group health plans in aggregate form based on their block of business in each state. Plan specific information is generally limited to: (1) identifying information for plans and issuers and other reporting entities; (2) the beginning and end dates of the plan year; (3) the number of participants, beneficiaries, or enrollees, as applicable; (4) the plan premium or premium equivalent (including employer vs. employee cost sharing); (5) TPA and stop loss fees; and (4) each state in which a plan is offered. TPAs and carriers should agree to submit those plan specific data elements on behalf of their clients. However, where TPAs are unwilling to submit this additional information, plans sponsors will need to submit those data files directly to CMS using its Health Insurance Oversight System (HIOS) platform. For a detailed discussion of these rules and how to directly submit data see Reporting Playbook.

Prohibition on Gag Clauses Regarding Price and Quality Information (No Delay – Good Faith Compliance)

CAA rules also prohibit group health plans from entering into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider that would directly or indirectly restrict a group health plan from providing provider-specific cost or quality of care information, electronic access to de-identified claims and encounter information for enrollees in a plan, or sharing of the above information/data with business associates in accordance with HIPAA standards. Such restrictions are colloquially referred to as "gag clauses." This requirement was effective December 27, 2020. Plan sponsors and advisors should have reviewed TPA agreements for gag clauses and removed them. Group health plans are required to report compliance with this provision annually to CMS by December 31 each year. 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. However, employer plan sponsors may need to make attestations for non-integrated concierge care or telehealth arrangements separately or where carriers or TPA are unwilling to make the attestation on behalf of their clients.

Broker & Consultant Compensation Disclosure

The CAA added a new compensation disclosure requirements for brokers and consultants to ERISA covered group health plans for contracts entered into, extended or renewed on or after **January 1, 2022** (absent further extension). Specifically, the CAA amends ERISA to require certain "covered service providers" (CSP) provide written information about their fees and services to a "responsible plan fiduciary." The "responsible plan fiduciary" is a plan fiduciary with authority to cause a plan to enter into, extend, or renew a contract or arrangement for plan services. Failure to comply with the disclosure requirements means that the service arrangement is not reasonable and is therefore an ERISA prohibited transaction. A CSP is a service provider that reasonably expects to receive $1,000 or more in total direct or indirect compensation from the plan in connection with providing a "covered service" to an ERISA-covered group health plan. "Indirect compensation" is compensation received by a provider from a source other than the plan, plan sponsor or the CSP, while "direct compensation" is that paid by the group health plan. For purposes of group health plans, CSPs are limited to providers of certain brokerage and consulting services.

Brokerage services provided to a covered plan are those with respect to selection of insurance products (including vision and dental), recordkeeping services, medical management vendors, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services. Consulting services are those related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services.

The disclosure must contain a description of the services to be provided, a statement of the entity's fiduciary status, and a description of "compensation" received by the CSP for services. The term "compensation" is defined broadly to include anything of monetary value except for non-monetary compensation valued at $250 or less throughout the term of the arrangement. For indirect compensation, the disclosure must describe: (1) the payer of the indirect compensation; (2) the amount (or formula or estimate) of the indirect compensation; (3) the services for which the indirect compensation will be paid; and (4) the arrangement between the CSP (or its affiliate or subcontractor) who receives the fees and the payer of the indirect compensation. Importantly, indirect compensation is defined as including compensation paid by a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan. Additionally, the disclosure must contain a description of compensation paid among the CSP, its affiliates and subcontractors if it is set on a transaction basis. Transaction-based compensation would include commissions, finder's fees or other incentive-based compensation related to the contract for services. The disclosure must describe the services for which such "shared compensation" is paid, and identify each payer and recipient (including status of recipient as an affiliate or subcontractor). Lastly, the disclosure must describe any compensation expected to be received in connection with the termination of the contract or arrangement as well as the manner in which compensation will be received.

For new and ongoing arrangements, the disclosure must be made reasonably in advance of the date that any contract or arrangement for brokerage or consulting services is entered into, extended or renewed. Also, if the compensation information initially provided changes over time, an update must generally be provided within sixty-days. A CSP must also act in good faith to correct any errors or omissions as soon as possible, but no later than 30 days after discovery of the mistake.

The No Surprises Act (No Delay – Good Faith Compliance)

The CAA included groundbreaking protections against surprise billing for emergency services, air ambulance services and certain services provided by a nonparticipating provider at a participating facility under the No Surprises Act (the Act). These provisions are effective for **plan years beginning on or after January 1, 2022**. They apply to both grandfathered and non-grandfathered group health plans, including church plans and non-federal governmental plans, as well as prescription drug plans. The Act does not apply to excepted benefits, or account based plans like HRAs or H-FSAs. Importantly, state law prohibitions on balance billing (generally applicable to insured plans) that are more stringent than those under the Act will also continue to apply. The Departments) also issued Interim Final Rules on the Act, in

addition to a Fact Sheet and Model Notice for inclusion with Explanations of Benefits (EOBs) and on public websites of group health plans and insurers.

Emergency Services

Under the Act, insurers and plans that cover emergency services cannot require prior authorizations for those services regardless of whether the health care provider furnishing such services is a participating provider or a participating emergency facility. The Act defines a participating provider or facility as one with which the plan has a direct or indirect contractual relationship with respect to furnishing a particular item or service, and a nonparticipating facility or provider as one where there is no existing contractual relationship (commonly referred to as in-network or out-of-network). Next, if emergency services are provided to a participant by a nonparticipating provider or at a nonparticipating emergency facility: (1) there cannot be any requirements or limitations on coverage that are more restrictive than if the services were provided by a participating provider or emergency facility, (2) cost sharing cannot be greater than if the services were provided by a participating provider or emergency facility, (3) cost sharing must be calculated as if the total amount that would have been charged by a participating provider or emergency facility was equal to the "recognized amount" for the services, and (4) any participant cost sharing must be applied towards any plan deductible and out-of-pocket maximums.

The recognized amount is the "qualifying payment" as determined for a service for a given year. A qualifying payment will generally be the median of contracted rates. The 2019 rates would set the 2022 amount (indexed by the Consumer Price Index) for the same or a similar service in the same geographic area. Rates for plans not in existence in 2019 would be based on contracted rates for services to be furnished in the first year. Subsequent regulations on how plans determine what constitutes a qualifying payment also must be issued by July 1, 2021. State laws establishing required payments will also govern and are not superseded.

A group health plan or insurer that receives a bill for emergency services provided by a nonparticipating provider or at a nonparticipating emergency facility must issue a notice of denial of payment or make an initial payment within 30 days after a bill is transmitted. The total payment is then calculated and billed later if the parties do not dispute the amount. Note that emergency services can, under certain circumstances, also include services furnished after the patient is stabilized and as part of outpatient observation if connected to the underlying emergency service.

Non-Emergency Services

Certain items or services furnished by a nonparticipating provider during a visit to a participating facility are also regulated under the Act. Unless the nonparticipating provider gives notice and gets patient consent (discussed below) the following rules, similar to those governing emergency services, apply: (1) cost sharing cannot be greater than if the services were provided by a participating provider, (2) cost sharing must be calculated as if the total amount that would have been charged by a participating provider or emergency facility was equal to the "recognized amount" for the services, (3) the plan must issue a notice of denial of payment or make an initial payment within 30 days after a bill is transmitted, with the total payment subsequently calculated and billed later, and (4) any participant cost sharing must be applied towards any plan deductible and out-of-pocket maximums.

Independent Dispute Resolution Process

The Act also provides a formal Independent Dispute Resolution (IDR) process to resolve disputes regarding out-of-network rates and payments. Under this IDR process either party (the plan or provider/facility) can initiate Open Negotiations during a 30-day period starting from the date the denial or initial payment is received. The Open Negotiations period is 30 days. Where there is no resolution at the

end of that period either party has four days to initiate an Independent Review by sending a notification to the other party and the Secretary of the applicable federal department (the Department of Labor for ERISA plans). The remainder of this process and the certification of entities to conduct Independent review will be the subject of subsequent rulemaking. The Act gives the Departments one-year from enactment (generally, late December 2021) to establish by regulation the IDR process under which a provider or facility or group health plan can make an appeal to a Certified IDR Entity that will conclusively determine the amount of the required payment under the rules of the Act. Subsequent regulations with address how entities become certified.

The parties generally will have three days to agree on a Certified IDR Entity or the Secretary will assign an Entity within 6 days. Ten days after selection, each party must submit a payment offer with supporting information. The Certified IDR Entity is required to make a formal determination within 30 days of selection. Interestingly, the Act includes listed additional factors that the IDR Entity can consider, such as the expertise of the provider and the market share of the facility. It also includes an express prohibition of certain factors including, usual and customary charges and the payment amount by a public provider, specifically Medicare, TRICARE or CHIP reimbursement rates. The IDR determined payment must be made within 30 days of the rendering of that determination. Certified IDR decisions are binding and not subject to judicial review absent evidence of corruption, fraud, misconduct, or exceeding the scope of their authority. The losing party (whose offer was not chosen) is responsible for paying the costs of the IDR process.

Healthcare Provider Requirements

Limitations on out-of-network billing and plan payments do not apply if a provider satisfies specific notice and consent requirements under the Act. If a participant makes an appointment 72 hours in advance, on the date of the appointment the provider must furnish a written notice (paper or electronic) in a format to be determine by regulations (by July 1, 2021) that includes a required consent to services, and the following information:

- Notice that the provider or facility is nonparticipating (or out-of-network),
- A good faith estimated amount that the provider or facility will charge,
- In the case of a nonparticipating provider at a participating facility, a list of other participating providers at the facility able to perform the service, and
- Information on whether a prior-authorization or any other medical management limitation may apply in advance of receiving the care.

The notice and consent document must be available in the 15 most common languages in the geographic region.

Beginning January 1, 2022, providers and facilities are also subject to a new notice and posting requirement under the Act. Providers and facilities must post on their websites, and provide to participants, a one-page notice including: (1) information on prohibitions on balance billing under the Act, (2) any state law requirements on amounts providers or facilities can bill when they are nonparticipating (out-of-network), and (3) the appropriate state and federal agencies to contact with possible violations of those provisions. Penalties for violations are up to$10,000 per occurrence.

Air Ambulance Services

The Act also addresses Air Ambulance bills, which generated a lot of the initial controversy surrounding balance billing. Where a participant receives services from a nonparticipating Air Ambulance provider: (1) cost sharing cannot be greater than if the services were provided by a participating provider, (2) any

participant cost sharing must be applied towards any plan deductible and out-of-pocket maximums, and (3) the payment process, Open Negotiation, and IDR rules discussed above governing payments and disputes apply. Note that other factors are subject to consideration in the Air Ambulance IDR process, including but not limited to, Air Ambulance vehicle type and population density of the pick-up location.

Air Ambulance providers are also required to submit detailed information to the Departments of Health and Human Services and Transportation on their fleet, operations, and services. Importantly, group health plans and insurers are also required to submit information to the Departments of Labor and Treasury on: (1) claims data for Air Ambulance services, (2) whether services were furnished on an emergency or non-emergency basis, (3) details on the affiliation of the provider of those services (e.g., hospital, municipal, private), (4) whether services were for a rural or urban location, (5) the type of aircraft used, and (6) whether the Air Ambulance provider has a contract with the plan or insurer. Provider, insurer, and group health plan reports are due 90 days after the end of the first calendar year to which the Act applies. Subsequent rulemaking will be required to clarify the reporting process as well as submission deadlines and frequency.

Conclusion

These sweeping new transparency requirements and patient protections will impact providers in addition to employers, insurers and TPAs. Compliance with all of these requirements should largely fall to insurers and TPAs (by contract), but employers that sponsor self-funded plans will ultimately remain responsible for compliance. Plan sponsors should become familiar with these new obligations and engage with their insurers and TPAs to make sure that these partners intend to facilitate group health plan compliance.

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