Compliance Plan

Transparency Rules and No Surprises Act

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This Compliance Plan represents a summary of the major implementation steps associated with these new laws.

The Departments of Labor, Treasury, and Health and Human Services are required to issue regulations implementing the No Surprises Act by July 2021, and implementing the Independent Dispute Resolution entity requirements by the end of 2021. Plan sponsors should continue to monitor federal regulatory and sub-regulatory guidance on the requirements. Plan sponsors should consult with Legal Counsel as to the applicability of these laws to their plan and its operations.

Segal is available to assist plan sponsors in all aspects of compliance with these requirements.

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No Surprises Act and Final Transparency Rule

This information is for educational purposes and is based upon guidance available as of February 16, 2021. Additional guidance is anticipated prior to the implementation effective dates, which may impact the contents of this document. Plan sponsors should consult with Legal Counsel as to the applicability of these laws to their plan and its operations.

Action	Responsible Party	Effective Date	Plan Actions
Identify Applicability			
Identify scope of applicability of Act to the group health plan. Most provisions apply to both grandfathered and non-grandfathered plans unless otherwise indicated. Retiree-only plans, excepted benefits, and individual account plans appear to be exempt, but no agency guidance has been issued.			
Monitor federal regulations and guidance throughout implementation period			
Plan/SPD Amendments			
Some items listed may sound familiar to non-grandfathered plans. However, the new rules are more expansive than the rules under the Affordable Care Act. Therefore, all plans should review current provisions to determine whether modifications are necessary. 1. If non-grandfathered, amend plan to eliminate ACA emergency room payment rules 2. Amend plan rules to cover emergency services without prior authorization 3. Amend plan rules to apply cost sharing in the same manner at participating and non-participating providers and facilities, both subject to and accumulating to the in-network deductible and pout-of-pocket maximum. 4. Define: • Emergency medical condition using the prudent layperson standard • Emergency department of a hospital to include an independent freestanding emergency department. • Emergency services 5. Amend plan to address non-emergency services provided at an in-network facility by an out-of-network provider		Plan years beginning on or after January 1, 2022	

Action	Responsible Party	Effective Date	Plan Actions
6. Amend plan to set forth standards for payment to a non-network provider or facility 7. Modify External Review procedures to include determinations regarding emergency services and air ambulances 8. Modify plan to allow "continuing care patients" to continue care after provider contract termination as required 9. Eliminate higher cost-sharing for non-participating providers if the participant was informed that the provider was a participating provider 10. Create complaint process			
Participant Communications and Notices			
General Review • Notify participants of changes to plan in a timely manner			
Advance Explanation of Benefits Form • Establish process to provide participants an Advance Explanation of Benefits Form including the required elements within the time frames established by the Act • The timeline is triggered by submission of notification of costs by a provider or facility.		Plan years beginning on or after January 1, 2022	
Issue new ID cards that include deductibles; out-of-pocket maximum; and telephone number and internet website address to seek consumer assistance information, such as network information		Plan years beginning on or after January 1, 2022	
Create process for resolving complaints by participants concerning the No Surprises Act and Transparency Rule		Plan years beginning on or after January 1, 2022	
Create process to verify the accuracy of the provider database and assure participant receives correct information on network providers		Plan years beginning on or after January 1, 2022	
Create process to offer price comparison guidance by telephone		Plan years beginning on or after January 1, 2022	
Draft Disclosure Notice for price look-up tool		Plan years beginning on or after January 1, 2023	

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Website Review			
General Review • Determine existing website capacity, technical specifications • Is website accessible for those with a disability? • Is there a place on the website to post required participant notices? • Is the plan using its own website or linking to a service provider website? • How will data transfer occur and what are the data requirements and testing schedule?		Plan years beginning on or after January 1, 2022	
Modify websites to include public disclosure of three required machine readable in-network; out-of-network; and prescription drug rate files or link to them (not applicable to grandfathered or retiree-only plans) 1. Negotiated payment rates for all covered items and services; 2. Allowed amounts and associated billed charges by out-of-network providers; 3. Pricing information for prescription drugs.		Plan years beginning on or after January 1, 2022	
Modify websites to include participant price look-up tool meeting the requirements of the Health Plan Transparency Final Rule, or link to it (not applicable to grandfathered or retiree-only plans) • The seven required content elements to determine cost-sharing are: Estimated cost-sharing; Accumulated amounts; In-network negotiated rates; Out-of-Network allowed amounts; Items and services in bundled arrangements, if applicable; Any coverage prerequisites (i.e. preauthorization, concurrent review, step therapy, fail first protocols); Disclosure Notice.		For first 500 services, Plan years beginning on or after January 1, 2023 For remaining services, plan years beginning on or after January 1, 2024	
Make available on the Internet website of the plan or issuer a price comparison tool meeting the requirements of the Act, that allows participant to compare cost-sharing by participating provider, geographic region		Plan years beginning on or after January 1, 2022	
Provide Notice about balance billing prohibitions on a public website, and include on each EOB,		Plan years beginning on or after January 1, 2022	

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Payment Methodology Modifications			
1. Determine plan's payment rates for out-of-network emergency services for 2022 and thereafter • Determine plan's median contracted rates for items or services furnished in 2022 – In 2022 plan must pay the median of the contracted rates recognized by the plan as the total maximum payment for the item or service on January 31, 2019, for the same or similar item or service provided by a provider in the same or similar specialty and in the geographic region in which the item or service is furnished, increased by a CPI percentage 2. Track regulations for payment methodologies for 2023 and thereafter (regulations to be issued by July 2021) 3. Determine what database to use for newly covered items and services for which there was no rate in 2019		Effective for plan years beginning on or after January 1, 2022; Determine 2019 rates in 3rd quarter 2021	
Establish process to verify whether participant has consented to receive services from out-of-network provider who provided services in an in-network facility; and that such consent meets the requirements of the Act; in such case, payment rules under Act do not apply		Plan years beginning on or after January 1, 2022	
Establish process to assure that plan pays recognized amount or sends notice of denial for emergency services within 30 calendar days after the bill is transmitted by the provider		Plan years beginning on or after January 1, 2022	
Out-of-Network Payments and Independent Dispute Resolution (IDR)			
Prepare to engage in negotiations with Out-of-Network Providers and Facilities 1. Review current service provider that handles out-of-network claims to determine whether they can comply with Act 2. Determine who will be responsible for notifying out-of-network provider/facility of denial or initial payment 3. Determine who will conduct negotiations with provider/facility prior to IDR		Plan years beginning on or after January 1, 2022	

Action	Responsible Party	Effective Date	Plan Actions
Determine who will be responsible for interacting with Independent Dispute Resolution Entity; and who will prepare the IDR payment offer • Assure that person has access to plan's median contracted rate and other necessary information to prepare offer		Plan years beginning on or after January 1, 2022	
Determine whether any state balance billing laws would apply to the plan (See Resources list) • If state balance billing laws apply, review existing program to determine how it will coordinate with federal law		Plan years beginning on or after January 1, 2022	
Air Ambulance Services			
Determine who will be responsible for Air Ambulance out-of-network claims and review payment methodology factors listed above		Plan years beginning on or after January 1, 2022	
Monitor regulations for how group health plans must submit reporting to Labor, HHS and Treasury concerning air ambulance claims data, after the agencies publish rulemaking		Plan years beginning on or after January 1, 2022	
Service Provider Contract Amendments			
General Review • Identify applicable service providers for each portion of the law and inventory network provider contracts • Assure that current contracts are easily accessible		Plan years beginning on or after January 1, 2022	
Network Provider/Preferred Provider Organization Contract Amendments: • Allow access to rates as by new laws • Establish process to transmit rate information, including testing schedule • Eliminate gag clauses that prevent the plan from providing provider-specific cost or quality information to referring providers, plan sponsors, participants • Require updated provider directories and directory maintenance • Create process to notify "continuing care patient" with respect to a provider/facility at the time of a termination of a contract (or change in terms of participation)		Plan years beginning on or after January 1, 2022	

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Third Party Administrator/Administrative Service Provider Contract Amendments: • Establish roles and liability for compliance; • Include 30-day payment and denial rules, new payment methodology • Include payment of IDR fees and costs • Including requirements for government reporting • Address website compliance • Address new ID Card requirement • Require production of Advance Explanation of Benefits; address process for distribution to participants • Require support for price comparison tool • Require maintenance of provider directories and mistake reporting • Eliminate gag clauses that prevent the plan from providing provider-specific cost or quality information to referring providers, plan sponsors, participants • Address responsibility for penalties for failure to comply or errors		Plan years beginning on or after January 1, 2022	
Direct Contracts with health care providers or facilities Amendments: • Eliminate gag clauses that prevent the plan from providing provider-specific cost or quality information to referring providers, plan sponsors, participants • Address continuity of care patients • Determine impact on Reference-Based Pricing arrangements		Plan years beginning on or after January 1, 2022	
Pharmacy Benefit Manager Contract Amendments: • Require reporting to federal government of prescription drug claims • Require access to negotiated rates as required by new laws • Address transmission of rate information to plan, including testing schedule • Establish process to transmit rate information, including testing schedule		Drug price reporting is effective December 27, 2021, and each June 1 thereafter	
Insurance Agreements • Amend to require compliance • Include role assignment and responsibility		Plan years beginning on or after January 1, 2022	
ERISA plans only • Require disclosure of consulting and broker fees under ERISA Section 408(b)(2)		Contracts executed on or after December 27, 2021	

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Information Technology			
Document workflow of a claim to help determine compliance responsibilities			
Address software and hardware needs			
Establish testing processes for data interchange and new technology/software			
Government Reporting			
Provide annual attestation that plan is in compliance with the gag clause prohibition rule (once regulations issued)		Awaiting regulatory guidance	
Prepare to submit prescription drug data reporting to federal government		December 27, 2021, and each June thereafter	
Report to Labor, HHS and Treasury concerning air ambulance claims data		Awaiting regulatory guidance	
Financial Planning			
Determine impact on plan costs			
Create implementation budget			
Determine impact on existing service provider relationships			
Resources			
https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage			
Public Law 116-260, Division BB https://www.congress.gov/bill/116th-congress/house-bill/133/text/pl			
State balance billing laws https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/state-balance-billing-protections			

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