

# Ensuring Compliance with Surprise Billing, Transparency, and Cost Reporting

***A Checklist for Employers Offering Self-Insured Group Health Plan Coverage***

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The Consolidated Appropriations Act (CAA), No Surprises Act (NSA), and the Transparency in Coverage Final Rule (TiC Final Rule) impose several new requirements on group health plans. For a fully-insured plan, the carrier will typically handle the additional requirements. For a self-insured plan, the responsibility of compliance lies with the employer as the plan sponsor. However, many of the requirements force employers to rely on their Third-Party Administrator (TPA) and others to implement appropriate measures to comply with these new requirements.

The following is a checklist of the various transparency requirements to assist employers who offer self-insured group health plans in determining which items the TPA will handle on their behalf and which things the employer is responsible for handling on their own (or for finding another solution). It would also be appropriate to confirm what costs, if any, may apply for the TPAs assistance with the requirements described below.

1. **No Gag Clause in Provider Contracts** - *Effective on December 27, 2020*

All gag clauses must be removed from relevant provider contracts. In addition, effective starting in 2023, carriers and health plans must submit an annual attestation of compliance with the prohibition on gag clauses in provider reimbursement contracts. The attestation is due each December 31st.

* Confirm the TPA will assist in making sure that provider contracts do not contain any gag clauses
* Confirm in writing (in the TPA contract or otherwise) that the TPA will submit an annual attestation of compliance each December 31st

1. **ID Cards / Provider Directory Accuracy -** *Effective for plan years beginning in 2022*

ID cards must include additional required information, including deductible and copay details.

Accurate provider directory information must be available online and by telephone, and the information is required to be verified and updated at least every 90 days. If an individual is provided inaccurate information by the provider directory stating that the provider or facility was a participating provider or facility, the plan may apply cost-sharing only equal to or less than it would for a participating provider or facility and must count such cost-sharing amounts toward any in-network deductible or maximum OOP.

* Confirm the TPA will provide ID cards with the required information
* Confirm the TPA will maintain an accurate provider directory OR will assume liability if the employer’s plan is required to pay out of network claims as in-network due to provider directory inaccuracies

1. **Surprise Billing Rules (Balance Billing Protection) -** *Effective for plan years beginning in 2022*

Balance billing generally is not permitted for: (i) out-of-network emergency services; (ii) out-of-network providers in an in-network facility; and (iii) out-of-network air ambulance services. Plan participants may only be asked to pay the in-network rates, and the plan must pay the difference as negotiated with the provider.

A model notice communicating this protection must be posted on the plan’s public-facing website and must also be included with all Explanations of Benefits (EOBs).

* Confirm the TPA will process claims in accordance with the surprise billing requirements
* Confirm to what extent the TPA will negotiate with providers to get a fair price for the services, potentially using the independent dispute resolution (IDR) process, and any costs associated with such negotiations
* Confirm the TPA will include the model notice, or something similar, on their public-facing website and on all EOBs

1. **Continuity of Care -** *Effective for plan years beginning in 2022*

When a provider or facility is no longer in-network or covered under the plan, participants must be permitted to continue care for up to 90 days under the same terms and conditions that were in place prior to the change in network or coverage.

* Confirm that upon a network change, the TPA will identify and notify affected individuals and provide an opportunity for participants to request transitional care

1. **Health Plan Data (Machine-Readable Files) –** *Required beginning July 1, 2022*

Machine-readable files with reimbursement rates for: (i) in-network provider rates for covered items and services; and (ii) out-of-network allowed amounts for covered items and services must be posted on the plan’s public-facing website, or on a TPAs public-facing website if there is a written statement confirming that the TPA will do so. The machine-readable files must be updated monthly and clearly indicate the date the filed was last updated.

* Confirm the TPA will post the machine-readable file on their public website and update the files monthly
* Confirm in writing (in the TPA contract or otherwise) that the TPA will handle this requirement on behalf of the plan so that the employer does not have to post the files on the employer’s public-facing website

1. **Drug Cost Reporting –** *Required beginning December 27, 2022 and annually in June thereafter*

A plan list file and 8 data files, along with narratives, containing certain information about the plan’s prescription drug and health care spending must be submitted annually to CMS (the RxDC Report). It is possible the information required for the RxDC Report will need to be gathered from several different sources (e.g., TPA, PBM, other vendors, employer), and that there may be multiple reporting entities involved in compiling and submitting data for the plan.

* Confirm which files, if any, the TPA will submit on behalf of the plan and whether the TPA will incorporate information from other vendors
  + If the TPA will not assist with the reporting, confirm how the plan information will be shared to allow the employer to report
* Confirm if there is additional information or files that must be reported and who will report it

1. **TiC Final Rules: Advanced Cost Estimate “Price Comparison Tools”** **–** *Effective for 500 items and services on January 1, 2023; effective for all items and services on January 1, 2024*

A price comparison tool, including estimates of cost-sharing for covered health care items and services from each provider, must be made available via a web-based tool as well as by phone or paper upon request.

* Confirm the TPA will provide the web-based price comparison tool, including estimates of cost-sharing for covered health care items and services from each provider, as well as making the information available by phone or on paper upon request

1. **TiC Final Rules: Advanced EOB –** *Delayed indefinitely*

Plans must provide an advanced notification of a good faith estimate of expected charges to participants.

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