Compliance Services

LOCKTON

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Appendix C: Details of the new transparency requirements

There are several sections in the CAA dealing with transparency concepts, most notably disclosures to plan participants and reporting to federal authorities. The new rules will generally be effective for the plan years that begin on or after Dec. 27, 2021, thus Jan. 1, 2022, for calendar year plans. If that is not the case, we note it below.

New disclosures

Insurance cards

The CAA requires any physical or electronic insurance identification cards to include the amount of the in- and out-of-network deductibles and the out-of-pocket maximums that apply under the plan, and contact details for enrollees seeking additional information.

Other plan information

Several new transparency rules plow the same ground covered by recently finalized Trump administration regulations imposing a variety of transparency-related requirements on group health plans. For example, the CAA requires the following disclosures:

- **Advance information about costs:** Upon request by a healthcare facility or other provider, or a plan participant, beneficiary or enrollee, the plan must provide an advance explanation of benefits that states whether the facility or other provider is in-network for the item or service to be provided, the contracted rate for that item or service, and a description how an individual may obtain the item or service from an in-network provider.
- **Price comparison information:** Plans must provide price comparison guidance via telephone and an internet website that enables an enrollee to compare the amount of cost sharing for which the individual would be responsible with respect to the specific items or services of any provider.
- **Network information:** Plans must update and verify provider directory information at least every 90 days and *respond within **one** day* to enrollee questions about a provider's network status. The plan must maintain a publicly-accessible website with information about all in-network providers and

facilities, and directory information for each of them. *The plan must pay any extra costs that are incurred by an enrollee that relies on any inaccurate directory information.*

- **Balance billing disclosures:** Part and parcel to the new surprise billing rules detailed in Appendix A, group health plans and insurers, healthcare facilities and other providers must also publicly disclose information about federal and state prohibitions and rules on balance billing, and contact information for appropriate state and federal agencies sufficient to allow an enrollee to report any problems.

  Lockton comment: For their part, healthcare providers are required to inquire of each individual requesting treatment whether they are enrolled in a healthcare plan, and provide notice of a good faith estimate of the expected charges for the plan enrollee's requested item or service.

Pharmacy benefit and other plan cost reporting

The CAA requires that within one year of enactment of the law (i.e., by Dec. 27, 2021) and annually thereafter, group health plans must provide the Departments of Labor, Treasury and Health and Human Services with a description of the plans' pharmacy benefits and costs, broken down in detail for the 50 most common and most costly prescription drugs utilized under the reporting plan.

In addition, plans will need to report the total spending by the plan, broken down by:

- Types of cost (hospital spend, different provider reimbursement, etc.)
- Total plan and participant spending on prescription drugs
- Average monthly premiums paid by the employer and plan participants
- Reductions in premiums and out-of-pocket costs associated with rebates, fees or other payments by drug manufacturers to the plan or the plan's administrators

Compensation disclosures

The CAA requires group healthcare plan fiduciaries to obtain disclosures, by brokers and consultants who contract with the plan to provide typical brokerage or consulting services, of the direct and indirect compensation the broker or consultant expects to receive (for example, direct base commissions, bonus commissions, revenue splits with other vendors engaged by the plan, and other sorts of indirect compensation).

Lockton comment: The CAA defines "consulting services" broadly. So broadly, in fact, that it appears to capture practically all of a group healthcare plan's service providers (e.g., wellness vendors, third-party administrators, stop loss carriers, etc.).

The broker or consultant must disclose:

- A description of the services to be provided to the plan
- If applicable, a statement that the broker/consultant plans to serve as a fiduciary to the plan
- A description of all *direct* compensation (e.g., fees) the broker or consultant expects to receive (in the aggregate or broken out by service)
- A description of all expected *indirect* compensation (including insurer or other vendor incentive payments, a description of the arrangement under which the indirect compensation will be paid, the payer of the compensation, and any services performed by the broker or consultant for which the indirect compensation will be paid
- Separately, any *transaction-based compensation* (e.g., commissions, finder's fees) for services provided by the broker or consultant, and the payers and recipients of the compensation

- A description of any compensation the broker or consultant expects to receive in connection with the contract's termination, and how any prepaid amounts will be calculated and refunded upon termination

The broker or consultant is required to provide the disclosure in writing to a responsible plan fiduciary "not later than the date that is reasonably in advance of the contract date," and any renewal date. The broker or consultant must also provide, upon request from a plan fiduciary or plan administrator, any other information relating to the compensation received by the broker or consultant in connection with its contract or arrangement with the plan.

These new disclosure requirements go into effect on Dec. 27, 2021.

> **Lockton comment:** The intent of this provision is to help ensure that plan fiduciaries, when engaging a broker or consultant to perform services on behalf of the plan, are apprised of the direct and indirect compensation the broker or consultant will receive. That, of course, will help the fiduciaries better gauge the value the plan is receiving.
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> Technically, the law does not require disclosure from the broker or consultant, due to the federal government's limited authority. Instead, it says the plan fiduciary violates its duties if it fails to obtain the disclosures, which effectively forces brokers and consultants to comply if they want to stay in business.

Through the looking glass … in the other direction

The CAA helps ensure employer-sponsored healthcare plans have access to certain cost and quality of care information. When entering into contracts related to plan benefits or administration (e.g., a group insurance contract or a third-party claims administration contract), plans are not permitted to agree to restrictions in provider network contracts that would prevent them from accessing cost and quality of care information and providing that information to participants or other service providers in accordance with HIPAA.

Plans must not be denied access to information that includes provider-specific cost and quality of care data, as well as specific data showing costs related to claims.

> **Lockton comment:** As with the compensation disclosure requirements described above, the target of this provision is not so much the plan *per se* but the entities contracting with the plan, yet the law seeks to obtain the result it wants (in this case, banning certain gag/confidentiality clauses in contracts with the plan) by imposing on plans an obligation not to enter into any contract that includes such clauses.

Although group health plans are required to have access to this specific cost data, healthcare providers and provider networks are allowed to prohibit plans from publicly disclosing the information received.

> **Lockton comment:** This ability of healthcare providers and networks to ban public disclosure of information they're required to make available to plans could be difficult to harmonize with other transparency obligations under federal law that *require* plans to publicly post aspects of their cost projections. We expect regulators will tell plan sponsors how to resolve these competing obligations.

There is no specified effective date to this requirement on plans to not agree to such gag/confidentiality clauses, meaning the provision is likely immediately effective. However, it is unlikely that it can be enforced without regulatory guidance.

Lockton comment: This new requirement would not seem to be objectionable to plans. Indeed, this is the type of data that many employer healthcare plans, particularly those that are self-funded, have sought in order to develop a full understanding of their costs. However, it has become increasingly common for healthcare providers and provider networks to refuse to provide this information to employers and their healthcare plan consultants. Typically, the objection has been justified under the rubric that the information is "proprietary."

What's next?

All the new transparency requirements are likely welcome additions for plan participants. From the plan sponsor's perspective, some of the new rules seem worthwhile but are relatively trivial, such as printing deductibles and out-of-pocket maximums on participants' insurance cards. Others are more meaningful even if challenging, such as ensuring participants' ability to obtain a good faith estimate of the cost of a healthcare service or ensuring the plan's brokers and consultants timely provide the required compensation disclosures. Maybe the most welcome new transparency rule is the one favoring enhanced access to additional data that will help plan sponsors manage their healthcare spend.

Ultimately, plan sponsors will be dependent on their plan's vendors (insurers, third-party claims payers, broker and consultants, etc.) to facilitate the plan's compliance with these transparency obligations, and will want to contractually bind the vendors to lending assistance. Sponsors will then need to be vigilant in ensuring the vendors are providing the disclosures, reports and other assistance they contractually agree to make.

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