Health Service Board-November 18, 2021
Transparency Regulation Summary

The Departments of Labor, Health and Human Services, and Treasury issued a set of FAQs delaying enforcement of the ACA health plan price transparency rule issued in November 2020 and providing some delay and guidance for the health plan provisions in the Consolidated Appropriations Act of 2021 (the "CAA").

While SFHSS, as the plan sponsor, is responsible for compliance with the CAA and price transparency requirements, due to the nature of the data needed SFHSS will delegate much of the responsibility to its carriers through contracting. As of this report, all SFHSS carrier partners have confirmed they are either in compliance already or working towards being in compliance by the given deadline and/ or deadline extensions.

The table below shows the provisions and descriptions of the rules. There are 6 pages total.

Provisions	Description	Enforcement Date and Commentary
Prohibition of Gag Clauses in Provider Contracting	Prohibit plans and issuers from entering into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from: (1) providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage; (2) electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee; and (3) sharing such information, consistent with applicable privacy regulations. In addition, plans and issuers must annually submit to the Departments an attestation of compliance with these requirements.	**December 27, 2020**, good faith compliance until Agencies issue implementation guidance and require submission of attestations of compliance in 2022.
ID Card Deductible and Out-of-Pocket Maximum Disclosure	Require plans and issuers to include in clear writing, on any physical or electronic plan or insurance identification (ID) card issued to participants, beneficiaries, or enrollees, any applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance.	Plan years beginning on or after **January 1, 2022**, with good faith effort to comply.

Provisions	Description	Enforcement Date and Commentary
Updated Provider Directory	Establish standards related to provider directories that are intended to protect participants, beneficiaries, and enrollees with benefits under a plan or coverage from surprise billing. These provisions generally require plans and issuers to establish a process to update and verify the accuracy of provider directory information and to establish a protocol for responding to requests by telephone and electronic communication from a participant, beneficiary, or enrollee about a provider's network participation status. If a participant, beneficiary, or enrollee is furnished an item or service by a nonparticipating provider or nonparticipating facility, and the individual was provided inaccurate information by the plan or issuer under the required provider directory or response protocol that stated that the provider or facility was a participating provider or participating facility, the plan or issuer cannot impose a cost-sharing amount that is greater than the cost-sharing amount that would be imposed for items and services furnished by a participating provider or participating facility and must count cost-sharing amounts toward any in-network deductible or in-network out-of-pocket maximum.	Plan years beginning on or after **January 1, 2022**, with good faith effort to comply.
Updated Billing Disclosure	These provisions will provide patients with financial peace of mind while seeking emergency care as well as safeguard them from unknowingly accepting out-of-network care and subsequently incurring surprise billing expenses. Bans surprise billing for emergency services. Emergency services, regardless of where they are provided, must be treated on an in-network basis without requirements for prior authorization. Bans high out-of-network cost-sharing for emergency and non-emergency services. Patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates. Bans out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances. Bans other out-of-network charges without advance notice. Health care providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.	Plan years beginning on or after **January 1, 2022**, with good faith effort to comply (model notice is available).
Continuity of Care	Establish continuity of care protections that apply in the case of an individual with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer. These protections ensure continuity of care in instances when terminations of certain contractual relationships result in changes in provider or facility network status.	Plan years beginning on or after **January 1, 2022**, with good faith effort to comply.

Provisions	Description	Enforcement Date and Commentary
Machine Readable File—In-Network Rates and Out-of-Network Allowed Amounts	Require non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to disclose on a public website information regarding in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services and negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files.	**July 1, 2022**
ACA Price Comparison Tool	Require plans and issuers to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request.	Plan years beginning on or after **January 1, 2023**, for 500 items and services, and plan years beginning on or after **January 1, 2024**, for all covered items and services.
CAA Price Comparison Tool	Require plans and issuers to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request. CAA has a provision that add a requirement that price information also must be provided over the telephone.	Plan years beginning on or after **January 1, 2023**, (combined with ACA Price Comparison Tool).

Provisions	Description	Enforcement Date and Commentary
CAA Pharmacy Drug Cost and Coverage Reporting	Include certain reporting requirements for plans and issuers. These reporting requirements primarily relate to prescription drug expenditures, requiring that plans and issuers submit relevant information to the Departments. This information includes general information regarding the plan or coverage, such as the beginning and end dates of the plan year, the number of participants, beneficiaries, or enrollees, as applicable, and each state in which the plan or coverage is offered. Plans and issuers must also report the 50 most frequently dispensed brand prescription drugs, and the total number of paid claims for each such drug; the 50 most costly prescription drugs by total annual spending, and the annual amount spent by the plan or coverage for each such drug; and the 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year. Additionally, plans and issuers must report, among other things, total spending by the plan or coverage broken down by the type of costs, including hospital costs and provider and clinical service costs, for primary care and specialty care separately; spending on prescription drugs by the plan or coverage as well as by participants, beneficiaries, and enrollees, as applicable; and the average monthly premiums paid by participants, beneficiaries, and enrollees and paid by employers on behalf of participants, beneficiaries, and enrollees, as applicable. Plans and issuers must report the impact on premiums of rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers with respect to prescription drugs prescribed to participants, beneficiaries, or enrollees in the plan or coverage, including the amount paid with respect to each therapeutic class of drugs and for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year. Finally, plans and issuers must report any reduction in premiums and out-of-pocket costs associated with these rebates, fees, or other remuneration. Finally, these provisions require the Departments to issue biannual public reports on prescription drug reimbursements under group health plans and group and individual health insurance coverage, prescription drug pricing trends, and the impact of prescription costs on premium rates, 10 aggregated in such a way that no drug or plan specific information will be made public. In addition, these reports must not include any confidential or trade secret information submitted to the Departments.	**Indefinitely** until further rulemaking or guidance, prepare for first reporting as of **December 27, 2022**.

Provisions	Description	Enforcement Date and Commentary
Machine-Readable File—Prescription Drugs	Require non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to disclose on a public website information regarding in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services and negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files.	**Indefinitely** until further rulemaking
Advanced Explanation of Benefits	Require plans and issuers, upon receiving a "good faith estimate" regarding an item or service as described in PHS Act section 2799B-6, to send a participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) an Advanced Explanation of Benefits notification in clear and understandable language. The notification must include: (1) the network status of the provider or facility; (2) the contracted rate for the item or service, or if the provider or facility is not a participating provider or facility, a description of how the individual can obtain information on providers and facilities that are participating; (3) the good faith estimate received from the provider; (4) a good faith estimate of the amount the plan or coverage is responsible for paying, and the amount of any cost-sharing for which the individual would be responsible for paying with respect to the good faith estimate received from the provider; and (5) disclaimers indicating whether coverage is subject to any medical management techniques. The notice also must indicate that the information provided is only an estimate based on the items and services reasonably expected to be provided at the time of scheduling (or requesting) the item or service and is subject to change and any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section of the statute.	**Indefinitely** until further rulemaking