GBS Compliance

# Three End of Year Transparency Deadlines to Remember

The Transparency Rules are a collection of regulations and statutory provisions intended to improve the health care industry and protect consumers. Some hopeful results include improving costs through increasing transparency and increasing competition, creating cost savings for both the consumer and the employers, protecting and helping consumers make more informed health care decisions, achieving improved health outcomes and driving innovation.

The Transparency Rules fall into two main categories: the Transparency in Coverage Final Rules (TiCFR) and the Consolidated Appropriations Act (CAA). Underneath the CAA umbrella, there are three separate rules that address transparency: the CAA No Surprises Act (NSA), the CAA Transparency in Coverage rules (not to be confused with the TiCFR), and the CAA Mental Health Parity and Equity Act (MHPAEA) reports. All of these rules are sometimes referred to collectively and generally, as the Transparency Rules.

The Transparency Rules add additional disclosure obligations and reporting requirements for health insurers/carriers/TPAs, health care providers, group health plans and the employers that sponsor those plans.

An employer that sponsors a group health plan should be aware of three upcoming end of year deadlines, each of which is described in more detail below.

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| Pharmacy Benefits & Drug Costs Report (RxDC) | December 27, 2022 is due date for the report covering 2020 and 2021 data |
| Price Comparison Tool for Participants | By the first day of the plan year starting on or after January 1, 2023 |
| Notice Regarding Patient Protections Against Surprise Billing | By the first day of the plan year starting on or after January 1, 2023 |

# Three End of Year Transparency Deadlines to Remember

## Pharmacy Benefits And Drug Costs Report (RxDC)

The CAA Transparency in Coverage provisions, commonly referred to as the Prescription Drug Data Collection (RxDC) report, require all employer-sponsored medical plans, both fully insured and self-insured plans, to submit each year a new prescription drug and health care spending report.

Reporting for the 2020 and 2021 calendar years is due December 27, 2022 and thereafter, the reports are due each June 1 based on prior calendar year data. For example, absent any extensions, the second report containing 2022 data is due June 1, 2023. There are separate TiCFR rules that require similar disclosure to participants, but that rule was delayed given the overlapping requirements under the CAA. The CAA RxDC report includes the following data:

P File

- For group health plans, this will be a P2 file

D Files

- D1 Premium and Life-Years *(see pages 20 to 23 in CMS instructions)*
- D2 Spending by Category *(see pages 23 to 30 in CMS instructions)*
- D3 Top 50 Most Frequent Brand Drugs
- D4 Top 50 Most Costly Drugs
- D5 Top 50 Drugs by Spending Increase
- D6 Rx Totals
- D7 Rx Rebates by Therapeutic Class
- D8 Rx Rebates for the Top 25 Drugs

Narrative Response

This is a Word or PDF document describing the impact of prescription drug rebates on premium and cost sharing and where other questions/topics are answered in narrative form.

The reports are submitted to the DOL, HHS and Treasury (the Departments) through a web portal set up by the DOL's Centers for Medicare & Medicaid Services (CMS). For more information: The reporting portal is found here and a detailed reporting instruction manual is found here.

Generally, employers that sponsor fully insured plans will rely on their insurance carrier to submit the report but may be asked to provide some basic information. Employers that sponsor self or level funded plans may be asked to provide information and may also have additional tasks. These employers should coordinate with their third-party administrator (TPA) or pharmacy benefit manager (PBM) to assist and make sure the report is completed on the plan's behalf. Typically, the TPA will complete P2, D1-D2 and the PBM will complete D3-D8. Remember employers maintain responsibility for complying with this rule even when others are acting on their behalf.

# Three End of Year Transparency Deadlines to Remember

## Price Comparison Tool For Participants

The Transparency in Coverage Final Rules (TiCFR) require group health plans, starting with their 2023 plan year, to offer an internet-based price comparison tool disclosing a (preliminary) list of 500 shoppable items and services. All remaining items and services must be added to this tool by their 2024 plan year. This information must also be available over the telephone and/or in paper form. The tool provides consumers with real-time cost estimates from different providers for covered items and services to enable shopping and comparing prices before receiving care.

A very similar price comparison tool is also required under the CAA, so to minimize compliance burdens and duplication, the Departments (DOL, HHS, IRS) aligned the effective dates and suggested possible proposed regulations that would allow compliance with the TiCFR rules to also satisfy compliance with the CAA No Surprises Act, as long as access via telephone (as required by the CAA) is also provided.

- January 1, 2023 : TiCFR
  Private disclosure to participants, first 500 items and services listed, remaining items added to list by 2024
- January 1, 2023: CAA No Surprises Act
  Price cost-sharing comparison tool for participants by phone and website (*original effective date 1/1/22*)

Most employers that sponsor group health plans will rely on their carrier or third-party administrator (TPA) to develop and maintain the internet price comparison tool as well as provide information via paper or over the phone. Employers should confirm that their carrier or TPA is on track for compliance by 2023. Remember employers maintain responsibility for complying with this rule even when others are acting on their behalf.

## Notice Regarding Patient Protections Against Surprise Billing

The CAA No Surprises Act (NSA) seeks to protect patients from surprise billing including those who get emergency care and certain non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers.

Participants who are enrolled in an employer sponsored group health plan must be notified of their rights and protections against surprise medical bills through the new model notice or alternatively, through a notice that contains all the core elements of the new model notice. The "version 2" model notice is found here.

## Three End of Year Transparency Deadlines to Remember

All employers that maintain a *public website for their group health plan* (different than a public facing website) should post the new "version 2" notice on that site by the first day of the plan year beginning on or after January 1, 2023.

Employers without a public group health plan website should be able to rely on their carrier (if group health plan is insured) or their TPA (if the group health plan is self/level funded) to post this notice on the carrier/TPA public website for the plan. Remember employers maintain responsibility for complying with this rule even when others are acting on their behalf.

Although it is not required, some employers that want to ensure their employees understand their rights and protections under the No Surprises Act are also voluntarily including the model notice in their annual notices packets provided at open enrollment and at hire for eligible employees. The "version 2" model notice is found here and easy to understand consumer information about the No Surprises Act (NSA) is found here.