GBS Health Benefits Compliance

Navigating Transparency Rules: Employer Compliance Resource

In the health benefits context, “Transparency” generally refers to a collection of related but independent rules and requirements from different legal and regulatory sources, intended to increase visibility into healthcare pricing, costs, and plan operations, and to support more informed decision-making at both the plan and individual level. These rules include the Transparency in Coverage Final Rules (TiCFR 2020), Consolidated Appropriations Act of 2021 (CAA 2021), the Consolidated Appropriations Act of 2026 (CAA 2026), and the proposed PBM Fee-Disclosure Rule (2026), although the proposed rule is listed here for reference only and is not addressed in detail below.

The checklist below provides a practical summary of the key compliance steps employer sponsors should consider for each transparency rule. The matrix that follows provides a more detailed side-by-side overview of each rule’s origin, purpose, requirements, effective date, and employer action items.

Quick Summary Compliance Checklist

TiCFR

- [ ] Confirm who is responsible for the public machine-readable files and obtain the live public URLs.
- [ ] Confirm the participant price-comparison tool works online and that the same information is available by phone or paper on request.
- [ ] Add contract language requiring the carrier/TPA to maintain TiC compliance and notify the plan of errors or outages.
- [ ] Keep screenshots, URLs, and periodic test results in a simple compliance file.

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Quick Summary Compliance Checklist

CAA 2021 Transparency — Gag Clauses

- [ ] Review carrier, TPA, PBM, network, and analytics contracts for any language that restricts access to cost, quality, or de-identified claims data.
- [ ] Require vendors to confirm that neither direct contracts nor downstream contracts contain prohibited gag clauses.
- [ ] Amend contracts to preserve the plan's right to receive and share permitted data with business associates.
- [ ] Make sure the annual gag-clause attestation is filed by December 31 and retain proof of submission.

CAA 2021 Transparency — Broker/Consultant Compensation

- [ ] Obtain compensation disclosures before entering, renewing, or extending broker/consulting contracts.
- [ ] Review both direct and indirect compensation, including commissions, referral fees, and affiliate payments.
- [ ] Document that the employer reviewed the disclosures and determined the arrangement was reasonable.
- [ ] Request updated disclosures if services or compensation sources change.

CAA 2021 Transparency — RxDC

- [ ] Identify who will submit the RxDC filing for each plan year and each plan option.
- [ ] Provide any needed employer data, such as enrollment or premium information, on the vendor's timeline.
- [ ] Review the filing roster and sponsor information before submission.
- [ ] Retain vendor confirmations, submitted files, and proof of filing.

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Quick Summary Compliance Checklist

CAA 2021 No Surprises Act

- [ ] Confirm the carrier/TPA applies in-network cost sharing and no balance billing for protected claims.
- [ ] Confirm the required notice is posted publicly and included on applicable EOBs.
- [ ] Review sample ID cards for deductible, out-of-pocket maximum, phone number, and website disclosures.
- [ ] Require provider-directory updates at least every 90 days and a process to answer network-status questions within one business day.
- [ ] Confirm continuity-of-care, price-comparison phone access, and IDR escalation processes are in place.

CAA 2021 Mental Health Parity Reporting

- [ ] Inventory NQTLs across medical, behavioral health, and pharmacy benefits.
- [ ] Obtain written comparative analyses from carriers/TPAs/PBMs for each applicable NQTL.
- [ ] Review whether the analysis addresses processes, strategies, evidentiary standards, and factors used both as written and in operation.
- [ ] Collect and retain supporting data and documentation so the plan can respond quickly to a regulator request.
- [ ] Treat incomplete analyses as a remediation item now, not after an audit request arrives.

Quick Summary Compliance Checklist

CAA 2026 PBM Transparency

- [ ] Inventory all PBM arrangements, including embedded PBM services through a carrier, and identify which contracts or renewals will be in scope.
- [ ] Update PBM/carrier contracts to require the reports, disclosures, audit rights, and pass-through terms the law will require.
- [ ] Decide whether the plan will want quarterly PBM reporting instead of only semiannual reporting.
- [ ] Build a fiduciary review process for PBM rebates, fees, spread, and other remuneration.
- [ ] Keep a documented record that the employer reviewed PBM reports and used them to monitor contract reasonableness.

Proposed PBM Fee-Disclosure Rule (2026)

Included for reference only; proposed rule not yet final

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Full Transparency Rules Matrix

The matrix below provides a side-by-side summary of each transparency rule's origin, purpose, requirements, effective date, and employer action items. It is intended as a practical reference tool for employer sponsors. For more in-depth guidance on any specific rule, please contact your broker or consultant team, who may have additional summaries or compliance resources.

Transparency in Coverage Final Rules (TiCFR)	Consolidated Appropriations Act (CAA) 2021			Consolidated Appropriations Act (CAA 2026)
	Transparency: No Gag Clause Rule, Disclosing Broker Compensation, and Pharmacy Benefits / Drug Costs reporting (RxDC)	No Surprises Act (NSA)	Mental Health Parity Reporting	
Origins of the Rule / Law				
Executive Order 13877 (U.S. President) June 24, 2019 Rule issued: November 12, 2020 Authority: Implements transparency-in-coverage requirements under ACA section 1311(e)(3) and PHS Act section 2715A.	H.R. 133 (116th Congress) 2019 Signed into law December 27, 2020			H.R. 7148 (119th Congress) 2026 Signed into law February 3, 2026
Purpose				
Intended to increase health plan price transparency so consumers can compare expected costs before receiving care, make more informed decisions, and help drive competition that may reduce overall health care spending.	Intended to improve health plan transparency and fiduciary oversight by banning gag clauses, requiring disclosure of broker and consultant compensation, and collecting prescription drug and health care spending data.	Intended to protect consumers from unexpected out-of-network medical bills and keep patients out of payment disputes between providers and health plans.	Intended to strengthen mental health and substance use disorder parity by requiring plans to analyze, document, and demonstrate that their nonquantitative treatment limits are comparable to those used for medical and surgical benefits.	Intended to increase transparency, accountability, and plan visibility into PBM arrangements so ERISA plans can better understand prescription drug pricing, ensure compensation is fully disclosed and passed through as required, and more effectively monitor fiduciary compliance.
Rule Overview				
The Transparency in Coverage Final Rule requires most non-grandfathered group health plans and health insurance issuers to make pricing information available in two main ways: through public machine-readable files and through participant-specific cost estimates. Public Machine-Readable Files: Plans must post public files on an open website and update them monthly to show in-network negotiated rates and historical out-of-network allowed amounts and billed charges for covered items and services.	The CAA 2021 transparency provisions are a group of related requirements designed to give plans, employers, participants, and regulators better access to health care pricing, compensation, and prescription drug spending information. First, the gag clause rules prohibit plans and issuers from entering into agreements that directly or indirectly restrict access to or sharing of provider cost or quality information, de-identified claims data, or the sharing of that information with business associates for plan administration and improvement activities.	The No Surprises Act has two main parts. First, it protects participants from surprise billing in two key situations: (1) emergency services, including air ambulance services, furnished by out-of-network providers, and (2) certain non-emergency services furnished by out-of-network providers at in-network facilities.	The Mental Health Parity reporting provisions are designed to strengthen mental health parity enforcement by requiring documented NQTL comparative analyses from plans and issuers and by directing the Departments to conduct oversight and public reporting. This law requires action from: (1) insured and self-funded group health plans and issuers, and (2) the Departments (DOL/HHS/Treasury).	CAA 2026 includes two related PBM transparency provisions for ERISA group health plans: a new PBM reporting requirement and an expansion of ERISA service-provider disclosure rules. First, the CAA 2026 directly amends ERISA to impose new PBM transparency, reporting, and compensation rules for ERISA group health plans. It requires entities providing pharmacy benefit management services, including through health

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Full Transparency Rules Matrix

Transparency in Coverage Final Rules (TiCFR)	Consolidated Appropriations Act (CAA) 2021			Consolidated Appropriations Act (CAA 2026)
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Rule Overview (continued)				
Participant-specific cost estimates: Plans must provide participants, beneficiaries, and enrollees with personalized cost-sharing information through an internet-based price comparison tool, with the same information also available by phone or in paper form upon request. That participant tool was phased in for 500 items and services for plan years beginning on or after January 1, 2023, and expanded to all covered items and services for plan years beginning on or after January 1, 2024. The participant disclosure is designed to function like an advance estimate and generally includes expected cost-sharing, applicable rates or allowed amounts, bundled-payment information, prerequisite notices, and balance-billing disclosures.	This includes both direct contracts (such as employer agreements with carriers, TPAs, PBMs, or other service providers) and indirect/downstream contracts those entities enter into with subcontractors or network owners if those terms effectively restrict the plan's rights. In addition, plans and issuers must annually submit (by December 31 of each year) a Gag Clause Prohibition Compliance Attestation confirming compliance with the prohibition. Even if a gag clause remains, an attestation must still be filed to identify the issue. Second, the broker and consultant compensation disclosure rules required covered service providers that provide brokerage services or consulting to ERISA-covered group health plans to disclose, before a contract is entered into, extended, or renewed, the direct and indirect compensation they reasonably expect to receive in connection with the services - if that compensation is at least $1,000. There is also a separate disclosure provision applicable in the individual market. Reporting on Pharmacy Benefits and Drug Costs (RxDC). Plans and issuers must annually submit information to the Departments on prescription drug and other health care spending, including data such as total health care spending by type of cost, prescription drug spending, average monthly premiums, and information on high-cost drugs and rebates.	In these situations (under 2), participants generally may be charged only the in-network cost-sharing amount, that amount must count toward the participant's deductible and out-of-pocket maximum, and providers generally may not balance bill the participant for the remaining amount -- except where a limited notice-and-consent exception is permitted. Second, the Act added several related consumer protection requirements that employers and plans should also review for compliance, including: • Balance billing disclosures, including public posting of surprise billing protections (on a public website and on each explanation of benefits for applicable items and services). • Participant ID card disclosures, including applicable deductibles, out-of-pocket maximum limitations, and a telephone number and website for more information. • Provider directory requirements (updated min of every 90 days and responses to enrollees within 1 day) • Continuity-of-care protections when a provider or facility leaves the network, allowing certain continuing care patients to continue in-network coverage for up to 90 days	Plans and issuers: must prepare and make available, upon request, a written comparative analysis showing that any NQTLs applied to MH/SUD benefits are designed and applied in parity with medical/surgical benefits, both as written and in operation. Note that the focus of the NQTL analysis is not on the outcome, but on the process used to determine and apply the NQTLs. The analysis must address the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs, and plans should be prepared to provide detailed supporting documentation and data. Departments: are responsible for ongoing oversight and public reporting and therefore must: 1) Request and review at least 20 comparative analyses each year from plans or issuers where there may be potential violations, complaints (or other circumstances the Departments determine are appropriate). 2) Submit an annual public report to Congress summarizing the analyses reviewed and identifying plans or issuers found noncompliant after a final determination.	plans. It requires entities providing pharmacy benefit management services, including through health insurance issuers, to furnish detailed reports to plans every six months, or quarterly if the plan requests them. Second, it also amends ERISA's service-provider disclosure rules to require PBM-related compensation disclosures, audit rights, and pass-through of specified rebates, fees, alternative discounts, and other remuneration to the plan. Together, these provisions are intended to give plan fiduciaries greater visibility into PBM pricing and compensation practices and stronger tools to monitor pharmacy benefit costs and contract reasonableness.

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Full Transparency Rules Matrix

Transparency in Coverage Final Rules (TiCFR)	Consolidated Appropriations Act (CAA) 2021 — Transparency: No Gag Clause Rule, Disclosing Broker Compensation, and Pharmacy Benefits / Drug Costs reporting (RxDC)	Consolidated Appropriations Act (CAA) 2021 — No Surprises Act (NSA)	Consolidated Appropriations Act (CAA) 2021 — Mental Health Parity Reporting	Consolidated Appropriations Act (CAA 2026)
Rule Overview (continued)				
	Based on the information reported, the Departments must publish a publicly available biennial report on prescription drug reimbursements, pricing trends, and the impact of prescription drug costs, rebates, fees, and other remuneration on premiums and out-of-pocket costs.	• Price comparison tool by website and phone (this provision is largely duplicative of the TiCFR price comparison tool requirements, except that the CAA/NSA also requires price comparison information to be available by phone upon request). • Advanced Explanation of Benefits (AEOB) and good faith estimate (GFE) requirements for scheduled services, including timing rules for GFEs (for uninsured or self-pay individuals). • Quick payment/denial, and independent dispute resolution (IDR) requirements.		
Effective Date				
Already in Effect/Ongoing	Already in Effect/Ongoing	Already in Effect/Ongoing	Already in Effect/Ongoing	Effective for plan years beginning on or after August 3, 2028 (for contracts, extensions, or renewals entered into on or after that date)
Action Items for Employers				
Confirm which vendor is responsible for the public machine-readable files and obtain the live URLs for the in-network rate file and out-of-network allowed-amount file; verify that the files are publicly accessible and updated monthly. Confirm which vendor is responsible for the participant price-comparison tool and test it periodically for common services to make sure it works online and that the same information is available by phone or on paper upon request.	**Gag Clause prohibition** Inventory all direct contracts that touch network access or claims data, including carrier, TPA, PBM, network, and analytics/vendor agreements, and ask each vendor to confirm in writing that neither the direct contract nor any downstream agreement contains a prohibited gag clause.	Confirm that the carrier/TPA claims system applies in-network cost sharing and prohibits balance billing for covered emergency services, covered non-emergency services at in-network facilities, and air ambulance claims, and ask how the vendor handles notice-and-consent exceptions. Confirm that the required surprise-billing notice is posted on a public website and included on EOBs for applicable items and services, and keep a screenshot and sample EOB in your compliance file.	Inventory every NQTL that could affect MH/SUD benefits, including prior authorization, concurrent review, step therapy, network admission standards, reimbursement rules, formulary design, fail-first rules, and out-of-network reimbursement methodologies across medical, Rx, and behavioral vendors.	Inventory all ERISA plan arrangements involving PBM services, including embedded PBM services through a health insurance issuer, and identify which contracts, renewals, or extensions will be in scope when the new law becomes applicable under your matrix's August 3, 2028 effective date.

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Action Items for Employers (continued)				
Add or review contract language requiring the carrier/TPA to maintain TiC compliance, promptly correct errors, notify the plan of outages or regulator inquiries, and provide supporting records if the employer is audited. Keep a simple monthly compliance file with the public URLs, date-stamped screenshots, results of spot-testing, and any remediation tickets or vendor explanations for outages or inaccuracies. Make sure participant communications, benefits websites, and HR contacts point members to the correct price-comparison access point so the tool is actually usable in practice. Do not spend time building a prescription-drug machine-readable file unless guidance changes; the Departments have deferred enforcement of that TiC requirement.	Review contract language for any restrictions on access to provider cost or quality data, de-identified claims data, or sharing that data with a business associate; remove or amend any provisions that limit scope, frequency, format, or location of access in an unreasonable way. Add language in direct contracts requiring the carrier/TPA/PBM not to enter downstream agreements that would indirectly restrict the plan's access to or sharing of required information. Decide who will file the annual Gag Clause Prohibition Compliance Attestation, and require written confirmation plus a copy of the submission by December 31 each year. If a vendor refuses to remove a prohibited provision, still file the attestation and document the clause, the vendor involved, the employer's requests to remove it, and any other corrective steps taken. **Broker/Consultant disclosure** Require 408(b)(2)(B) disclosures before every new, renewed, or extended broker/consulting arrangement if the provider expects to receive at least $1,000 in direct or indirect compensation. Review the disclosures for indirect compensation, referral fees, commissions, revenue sharing, and affiliate payments, and document a fiduciary review of whether the compensation is reasonable and whether conflicts of interest exist.	Review a sample physical and electronic ID card to confirm it shows applicable deductibles, out-of-pocket maximums, and a phone number and website for more information. Require regular provider-directory compliance reports showing how the directory is updated, how network status questions are answered within one business day, and how members are protected with in-network cost sharing when the directory or response is wrong. The No Surprises Act also requires plans and issuers to update and verify directory accuracy at least once every 90 days. Build a continuity-of-care workflow for provider or facility terminations so that affected continuing care patients are identified, notified, and offered the right to continue in-network coverage for the transitional period. Test the price-comparison tool and phone process periodically, even if the same function already exists for TiC, because NSA/CAA expects the information to be available by phone upon request. Confirm with the carrier/TPA who handles initial payment or denial, open negotiation, IDR submissions, and external review support, and require escalation reports for disputes with unusual volume or dollar value. Track AEOB/GFE separately from the core NSA items: the insured AEOB framework is still in rulemaking, while current GFE timing rules are principally live for uninsured or self-pay individuals	Require the carrier / TPA / PBM / behavioral-health vendor to provide a written comparative analysis for each applicable NQTL, not just a general statement that the plan is "parity compliant." The final rules require six content elements, including demonstrations of comparability and stringency both as written and in operation. Ask for the underlying documentation and data up front, including policies, criteria, committee materials, denial and appeal data, access metrics, reimbursement methodologies, and any vendor rules used to apply the NQTL. Review the analyses with a fiduciary or compliance committee and look specifically for unsupported factors, weak evidentiary standards, missing data analysis, or material access differences that are not explained or remediated. Establish a rapid-response process so the employer can produce the comparative analysis within 10 business days if requested by a Department and can also respond to participant requests tied to an adverse MH/SUD benefit determination. Add contract language requiring vendors to cooperate with comparative-analysis requests, provide supporting data on short notice, help with remediation, and assist with any participant notice obligations if a final determination of noncompliance is issued.	Amend PBM and carrier contracts now to require the data and rights the law will expect: semiannual reports, quarterly reporting on request, compensation disclosures, audit rights, pass-through of specified rebates/fees/alternative discounts/other remuneration, correction rights, and access to supporting data. For insured or ASO arrangements with an embedded PBM, require the issuer to confirm in writing how PBM reports and compensation information will be flowed through to the employer-sponsored plan. Decide whether you want quarterly reporting for higher-spend plans or plans with known specialty-drug pressure, so that right can be built into contract language now rather than negotiated later. Create a standard PBM review dashboard for fiduciaries that looks at spread/reimbursement differences, rebates, fees, alternative discounts, other remuneration, and any trends that suggest misaligned incentives or unreasonable compensation. Preserve a real audit process, not just paper rights: decide who can perform the audit, what data the PBM must provide, what sampling or claims detail will be available, and how disputes over incomplete disclosures will be escalated.

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Action Items for Employers (continued)				
	Ask for updated disclosures whenever services, compensation sources, or affiliates change during the term of the arrangement. Keep the disclosures, review notes, and approval record with the contract file so you can show that the employer actually reviewed the information before agreeing to the arrangement. **RxDC Reporting** Identify who is submitting the RxDC report for each plan year and each plan option, and get the allocation of responsibility in writing from the carrier, TPA, and PBM. Require the reporting vendor to confirm which files it will submit, what employer data it needs, and when that data is due from the employer. Review the plan list, premium data, and any employer-supplied fields before submission so the employer can catch wrong plan names, missing plan options, or incorrect sponsor information. Retain copies of the submitted files, attestation/confirmation receipts, vendor certifications, and any assumptions or data mappings used in the filing. Review the public biennial RxDC report when issued and use it as a discussion tool with the PBM/carrier on rebate flow, high-cost drugs, and premium drivers.		If an analysis is weak or incomplete, treat that as a remediation project now rather than waiting for a DOL/HHS/Treasury request.	Document fiduciary review of the PBM reports and disclosures so there is a record that the employer used the information to assess contract reasonableness and ongoing monitoring of pharmacy benefit costs.

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This document is not intended to be exhaustive, nor should any information be construed as tax or legal advice.

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