

# **Consolidated Appropriations Act including the No Surprises Act**

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## Overview

### Summary

This document provides an overview of the Transparency in Coverage [final rule](#), and the health care provisions from the Consolidated Appropriations Act/No Surprises Act with an update on Florida Blue's implementation of these requirements. This information **can be used with external stakeholders** (members, groups, brokers, consultants, etc.) for both Florida Blue and Truli for Health business.

The following material is organized by the effective date for each requirement based on the most recent guidance available, which may be different than the requirement's original effective date.

- The regulations for the Transparency in Coverage and the No Surprises Act are complex and have broad impacts across the health care industry for insurers, providers, brokers, groups, and patients.
- Federal agencies are continuing to develop regulations to provide specific instructions on how these provisions should be implemented. In some cases, these regulations may alter either or both the requirements of a specific provision and its effective date. Insurers are expected to make good faith efforts to comply based on available information and a reasonable interpretation of the statutes.
- The Federal Employee Program (FEP) is impacted by this legislation, and the requirements are being addressed by the Blue Cross and Blue Shield Association. Please contact Lindsay Mitchelson with any questions related to FEP impacts.
- We are actively reviewing operational procedures, documentation, and customer-facing tools for potential impacts and modifications that will be necessary to comply with the law. Please note that self-insured groups are ultimately required to demonstrate compliance with these requirements, and we will work with our self-insured clients to assist with their compliance efforts.
- As we work to implement these provisions, we will not know the full extent of any operational changes needed, whether effective dates will be impacted, or how these changes could affect future costs such as premiums and/or administrative fees until they are fully defined and implemented.
- **Update 1.13.22:** Continuity of Care (COC) for ASO Groups on the Do Not Contact List for Provider Termination Notification. Process of COC when Fully Insured Groups cancel.
- **Update 2.2.22:** We have updated the Surprise Billing section on page 7 to add links for the surprise billing model notice for use by insurers and group health plans.
- **Update 6.6.22:** We have updated various provisions to include new implementation information and streamlined content for other provisions that have already been implemented or are deferred pending additional guidance.

### Details

Use this document to access the most up-to-date project status of each work effort related to the Consolidated Appropriations Act (CAA) and No Surprises Act.

Please route any additional questions to your Sales team.



# **Provisions Currently Effective**

# Mental Health Parity

## Section 203

### Effective January 1, 2022 or Earlier

#### Overview

- Requires group health plans and health insurance insurers offering individual or group coverage to perform and document comparative analyses of the design and application of nonquantitative treatment limitations (NQTL) used for mental health and substance use disorder (MH/SUD) benefits as compared to medical and surgical (med/surg) benefits.
- Provides the [DOL Self-Compliance Tool](#) to support the evaluation and documentation of:
  - The specific plan or coverage terms regarding the NQTLs and the med/surg and MH/SUD benefits to which the terms and NQTLs apply;
  - The factors used to determine that the NQTLs apply to med/surg or MH/SUD benefits;
  - The evidentiary standards used to evaluate the factors and any other source or evidence relied upon to design and apply the NQTLs to med/surg or MH/SUD benefits;
  - The comparative analysis demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits, as written and in operation, are comparable to and no more stringent than those used to apply it to med/surg benefits; and
  - The specific findings and conclusions by the plan/insurer on whether it is in compliance.
- Requires analysis results to be made available to state and federal authorities upon request and be provided with other relevant information including the factors used to determine the NQTL, the evidentiary standards used to determine the NQTL and the results of the analyses.
- If a plan is found to be non-compliant, the plan must specify the actions it will take to come into compliance and provide a new comparative analysis demonstrating compliance within 45 days of the initial determination of non-compliance.

#### Implementation Status

- This requirement did not change the existing mental health parity definitions or benefit standards — it only standardized the tool used for conducting parity analysis and defined timeframes for providing results to inquiries from state and federal agencies. For more information on how the Consolidated Appropriations Act affects the mental health parity requirements, please refer to this [guidance](#).
- Requests from state or federal agencies regarding mental health parity analysis should be provided to us in order to determine the appropriate response and/or level of support needed for groups.
- For fully insured groups, we will conduct the mental health parity analysis and respond to related inquiries from state or federal agencies.
- Self-insured groups are responsible for demonstrating compliance with mental health parity requirements. We will work with our self-insured groups to provide information that assists them in developing a response to state or federal agencies.

# Agent/Broker Compensation Statements

## Section 202

### Effective December 27, 2021

#### Overview

- Requires brokers and consultants to disclose to group health plan sponsors any direct or indirect compensation they receive for brokerage services or consulting when that compensation is valued at over \$1,000 (increases annually for inflation) for services. Does not apply to non-monetary compensation under \$250.
- Requires insurers to disclose to enrollees in the individual market or enrollees purchasing short-term limited duration insurance any direct or indirect compensation paid to an agent or broker associated with enrolling individuals in that coverage prior to an individual finalizing plan selection. This disclosure must also be included with any documentation confirming an individual's enrollment.

#### Implementation Status

- On September 16, 2021, federal agencies released a [proposed rule](#) related to the implementation of these statements. This rule only outlined the requirement to implement statements for the individual and short-term limited duration (STLD) markets for December 27, 2021. Further rulemaking will be conducted for this provision, and we will provide more information as it becomes available.
- Amends ERISA and the Public Health Service Act to require covered service providers (i.e., brokers and consultants) to disclose to group health plan sponsors any direct or indirect compensation they receive for brokerage services or consulting—terms that are defined very broadly. Applies when indirect or direct compensation is valued at over \$1,000 (increases by inflation) for services. Does not apply to non-monetary compensation under \$250.



## Surprise Billing

Sections 102 - 104

### Effective January 1, 2022

- Patients will be responsible for only in-network cost-sharing amounts, including deductibles, in emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider.
- Air ambulance providers are subject to these rules, but ground ambulance services are not.
- Establishes the benchmark for initial payments to out-of-network providers as the qualifying payment amount (QPA) — the median of the plan or insurer’s contracted rates for the item or service in that geographic region.
- If the out-of-network provider does not accept the QPA as payment, plans and providers have 30 days to negotiate a payment rate after the initial payment is rejected or a denial issued by the plan.
- If the negotiations are not successful, then the parties can utilize an independent dispute resolution (IDR) process. Under the IDR process, each entity will submit their offer for payment to an IDR entity for consideration and the IDR entity is expected to select the offer closest to the QPA as the appropriate out-of-network payment rate. The losing party is responsible for payment of the IDR process administrative fees.
- Out-of-network providers will be prohibited from balance billing patients. However, providers can balance bill if they give the patient notice of their network status and an estimate of charges 72 hours prior to receiving out-of-network services, and the patient provides written consent to receive out-of-network care.

### Implementation Status

- Some of the No Surprises Act requirements are already included in our plans; therefore, no changes are needed to comply with these provisions. This includes allowing a child beneficiary to have an in-network pediatrician assigned as their PCP and not requiring an authorization or referral for in-network OB/GYN services.
- Our plans also include out-of-network cost sharing protections for emergency services; however, the No Surprises Act expands those protections. Therefore, for all plans, member cost sharing amounts for out-of-network emergency services (facility, physician, ambulance) will be updated to reflect the plan’s in-network cost sharing amounts. Member cost sharing for non-emergency services performed by an out-of-network provider at qualifying in-network facilities will also reflect in-network amounts. This cost sharing will apply to the member’s in-network plan year deductible and out-of-pocket maximum amounts.
- For all plans, we will determine the QPA in accordance with state and federal laws for use as the initial payment to out-of-network providers. Based on the recent court ruling regarding the use of federal QPA methodology, we are awaiting further guidance on next steps.
- We are still evaluating our existing processes for handling payment disputes to determine what updates are needed to support this new IDR process. Additional information on operational changes and the related assistance available to groups will be provided at a later date.

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## Surprise Billing, *continued*

Sections 102 - 104

### Effective January 1, 2022

- A notice outlining surprise billing protections is required to be provided to members by group health plans and insurers. Providers and hospitals are required to publicly post rules banning surprise bills on their websites and in a one-page notice given to patients at the time of service.
- Group health plans and insurers must allow for an external review to determine whether surprise billing protections are applicable when there is an adverse determination by a plan or insurer.
- Plans must allow child beneficiaries to have an in-network pediatrician assigned as their primary care provider.
- Plans cannot require an authorization or referral for OB/GYN services performed by an in-network provider specializing in OB and/or GYN services.

### Implementation Status

- The Florida Blue model notice for use by insurers and group health plans to provide enrollees with information on their rights and protections against surprise medical bills can be found here: [English](#) and [Spanish](#) versions are available.
- The Centers for Medicare & Medicaid Services (CMS) has also created a new public website, [cms.gov/nosurprises](https://cms.gov/nosurprises), to provide information on the surprise billing rules and protections.



## Revisions to ID Cards

## Section 107

### Effective January 1, 2022

#### Overview

Requires individual and group health plans to identify on insurance cards the amount of the in-network and out-of-network deductibles and out-of-pocket maximums. Cards will also need to provide a telephone number and website where individuals can seek consumer assistance information.

#### Implementation Status

- We have updated our member ID cards as of October 1, 2021, to comply with this provision. We have also added Virtual Visit PCP and Specialist copayment amounts to all ID cards and added Open Access Network to the BlueCare and Simply Blue HMO ID cards. Our digital ID cards have also been updated to reflect this new format. (*Exception:* Truli ID cards will not include the Virtual Visit PCP and Specialist copayment amounts.)
- Groups with custom or non-standard ID cards should contact their Sales representative for more information about changes to their ID cards.
- Sample images of the new ID cards can be found in the October 28 Sales News [article](#) titled “No Surprises Act: Update on ID Card Revisions”.
- Mass mailings of new ID cards is not being performed. All new members, current members who have changes to their coverage that affects the cost information displayed on the ID card, and members who request a replacement ID card will receive new ID cards in the new format.

### Effective January 1, 2022

#### Overview

- Requires group health plans and insurers offering group and individual health plans to establish a verification process to confirm directory information at least every 90 days, including removing providers or facilities who are non-responsive.
- Requires plans to establish a response protocol to respond to member network questions within one business day and retain communications for at least two years.
- Requires plans to maintain a provider directory available to consumers online that includes a list of the in-network providers and facilities along with standard provider information: name, address, specialty, phone number and digital contact information for the provider or facility.
- If a member provides documentation that they received incorrect information about a provider's network status prior to a visit, provides for the patient to only be responsible for the in-network cost-sharing amount and for the visit to apply to the member's deductible or out-of-pocket maximum.
- These new federal requirements apply nationally to all health insurers and the maintenance of their online provider directories. Members who utilize online provider directories from health plans in other states can expect to see the same rules applied to those directories as well.

#### Implementation Status

- On August 20, 2021, federal agencies released [guidance](#) instructing insurers to implement this provision based on a "good faith" interpretation of the statutory language. Further rulemaking will be conducted for this provision, and we will provide additional information as it becomes available.
- We will continue to apply our existing processes to verify the network status of our providers and make related updates to maintain our provider directories in accordance with the statute. Member cost sharing will be limited to in-network amounts in situations where documentation shows that our directory information was incorrect regarding the provider's network status prior to the visit or service.

# Continuity of Care

## Section 113

### Effective January 1, 2022

#### Overview

- For individuals who are undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or terminally ill, group health plans and insurers must provide 90 days of continued, in-network care (“transitional care”) if (1) a provider or facility leaves the network (except for failure to meet quality standards or for fraud); or (2) a fully insured group terminates a contract with a health insurer.
- Transitional care is available for members in the individual and group (fully insured and self-insured) markets when there is a provider network status change, and for members of fully insured groups when the group terminates a contract with the insurer.
- A “serious and complex condition” is defined as: (1) an acute illness serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (2) a chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.
- Requires the group health plan or insurer to notify individuals receiving care from one of these providers or facilities of the availability of transitional care whenever there is a provider network change or an insurer change for members of a fully insured group. For those eligible individuals, we will provide the option for the member to continue care during the transitional period (lesser of 90 days or until the individual is no longer a continuing care patient).

#### Implementation Status

- On August 20, 2021, federal agencies released [guidance](#) instructing insurers to implement this provision based on a “good faith” interpretation of the statutory language. Further rulemaking will be conducted for this provision, and we will provide additional information as it becomes available.
- Protections have been developed for enrollees in both individual and group health insurance coverage to ensure continuity of care in instances when terminations of certain contractual relationships result in changes in provider or facility network status. We are reviewing our existing continuity of care protocols to determine necessary changes as of January 1, 2022, and will work directly with impacted members to support their transition of care. Any updates to these protocols will be communicated at a later date.

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### Effective January 1, 2022

- Requires providers subject to this provision to accept the continued in-network payment as payment in full and comply with all policies, procedures and quality standards imposed by the plan or insurer.
- **For ASO Groups on the Do Not Contact List for Provider Termination Notification.**  
It is very important to note that, due to the No Surprises Act, groups cannot be excluded from this requirement (per guidance from Legal) to notify members of their Continuity of Care (COC) rights. This means that if a group is on the Do Not Contact List specifically excluding them from provider termination notices the group/member will not receive the initial termination notice but will later receive a COC notification. This may cause some confusion. In an effort to help the Sales Team understand the member experience in this scenario, we have provided the below outline:
  - We are in negotiations with “abc” Hospital and it appears the contract may terminate, so we notify all members who have the provider in the last 12 months. This mailing happens 30 days prior to the contract termination. The Do Not Contact List is applied to this mailing; therefore, members and group Decision Makers would not receive the notification.
  - Negotiations are failing with “abc” Hospital, so we have to kick off the COC process. We identify all members in active treatment and send a letter. This would be inclusive of groups on the Do Not Contact List.
  - Members who enrolled on group health plans on the Do Not Contact List would not receive the letter from the first bullet, but they will receive the letter from the second bullet.

- **When Fully Insured Groups have been cancelled.**  
Due to the Section 113 mandate, we will be required to extend coverage for certain qualifying members. **The extended coverage period begins once we notify members and lasts for 90 days.** In response to the mandate, we are communicating recently canceled groups to internal sales stakeholders for a 7-day outreach period to support possible reinstatement efforts. After the 7 days, member notification letters will be mailed to these members indicating that their policies are canceled and that they may be eligible for the extended coverage.

Here are the letters we’re sending to members:

- [Cancellation Due to Non-Payment](#)
- [Cancellation Group Request](#)
- [Coverage Has Ended](#)

You, your groups, and members will all receive communications throughout the process of a cancellation due to non-payment. For example, you will receive routine notification emails about which groups are cancellation due to non-payment.

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## Continuity of Care, *continued*

## Section 113

### Effective January 1, 2022

When a group requests cancellation or has missed payment, we will let you know. Requested cancellations are rarely reinstated. This means there is little risk of sending out notifications in error for this group of cancellations.

- When a group is canceled due to non-payment there is a risk that notification would go out to the group members when the group has no intention of canceling or is just late paying.
- In these instances, a 7-day period is being imposed upon these groups. What that means is that a group that has a cancellation for non-payment will not be flagged for a notification to be created for at least 7 days after the cancellation has been processed
- This is intended to do two things:
  - Reduce the amount of notification that go out to group members that will ultimately reinstate
  - Give internal teams an opportunity to communicate with the groups about what will happen if payment is not received

For groups that end up on the list, custom daily email notifications will be sent to the aligned internal sales teams (including identified back-ups) to help make internal team members aware without the sales teams having to actively monitor a centralized list.



# Good Faith Estimates for Uninsured Patients

## Section 112

### Effective January 1, 2022

#### Overview

- Providers and facilities are required to provide uninsured or self-pay patients with a good faith estimate for the cost of care being considered or scheduled. For this provision, “uninsured” patients include those enrolled in short-term limited duration plans or any other non-ACA individual health plan (excepted benefits, health care sharing ministries).
- Since this provision requires providers and facilities to produce these estimates, there is no further action needed by group plans or insurers.

#### Implementation Status

N/A



# Prohibition on Gag Clauses on Price and Quality Information

Section 201


## Effective January 1, 2022

### Overview

- Bans gag clauses in contracts between providers and health plans that prevent enrollees, plan sponsors, or referring providers from seeing cost and quality data on providers.
- Bans gag clauses in contracts between providers and health insurance plans that prevent plan sponsors from accessing de-identified claims data that could be shared, under HIPAA business associate agreements, with third parties for plan administration and quality improvement purposes.
- Notices have been sent to providers with gag clauses currently in their contracts informing them of the new regulations.

### Implementation Status

N/A



# **Provisions with Future Effective Dates**





# Machine Readable Files for In-Network Rates, Out-of-Network Payments

## Transparency in Coverage Rule

### Effective July 1, 2022

#### Overview

- The Transparency in Coverage final rules require non-grandfathered group health plans and insurers offering non-grandfathered coverage in the group and individual markets to disclose information in three separate machine-readable files:
  - 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.
- These files must be posted on a publicly available website and updated monthly.

#### Implementation Status

- On August 20, 2021, federal agencies released [guidance](#) delaying the publication date for the in-network and out-of-network files from January 1, 2022, to July 1, 2022. Disclosure of the prescription drug file was deferred until further rulemaking is completed.
- As of July 1, 2022, Florida Blue and Truli for Health will post the in-network and out-of-network MRFs at the following location: <https://www.floridablue.com/members/tools-resources/transparency>.
- The site will also include a Table of Contents file with specific details on how to identify the file that applies to a specific health plan.
- Groups may copy and paste the above link to their public website in order to comply with these rules.
- These files are extremely large (minimum file size is 20 GB) and are designed to allow researchers, regulators, and application developers with data related to payment rates for health care services.
- Due to the size of these files, an individual's ability to view or download these files will be dependent on their hardware, browser, and internet speed.
- The data on these files does not reflect the application of benefits or cost-sharing (deductibles, copayments, coinsurance) for a specific health plan.

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# Machine Readable Files for In-Network Rates, Out-of-Network Payments, *continued*

Transparency in Coverage Rule

Effective July 1, 2022

## Implementation Status

- Each MRF uses a standard data format and schema (JSON) defined by federal agencies.
- For fully insured and Minimum Premium Program (MPP) groups, there will be one MRF per plan network (BlueOptions, BlueCare, etc.).
- For self-insured groups, there will be one MRF per plan network (BlueOptions, BlueCare, etc.) per group employee identification number (EIN). Users should contact their employer directly to obtain their EIN.
- All MRFs will only include rates for benefits that Florida Blue or Truli for Health administers – rates for benefits that are “carved out” to other vendors (i.e., pharmacy) will have to be obtained from that vendor.

## Reporting on Pharmacy Benefits and Costs

### Section 204

### Effective December 27, 2022

#### Overview

- Requires group and individual health plans to report annual data to HHS, the Department of Labor, and the Department of Treasury on drug utilization and spending trends. The report includes total spending on health care services by type (e.g. hospital, primary care, prescription drugs, etc.).
- Health plans will be required to include information on how rebates from manufacturers impact premiums and out-of-pocket costs, the amount of rebates by therapeutic class, and the amount of rebates for each of the 25 drugs yielding the highest amount of rebates.
- Requires HHS to produce a publicly available aggregate report on these prescription drug data and trends (no drug or plan-specific information will be made public) 18 months after the first report is received and bi-annually thereafter.

#### Implementation Status

- On August 20, 2021, federal agencies released [guidance](#) delaying the effective date for this reporting by one year, from December 27, 2021, to December 27, 2022.
- Effective December 27, 2022, insurers and group health plans must report information on plan medical costs and prescription drug spending for the 2020 and 2021 plan years to the Secretaries of HHS, Labor, and the Treasury. Future rulemaking will provide more details on these reporting requirements, and we will outline how we will support our group clients based on those rules.
- Florida Blue and Truli for Health will only report data on benefits that we administer. Groups that have pharmacy or other benefits that are “carved out” to other vendors will need to work directly with that vendor to ensure related reporting requirements are met.

# Price Comparison Tool

## Section 114

### Effective January 1, 2023

#### Overview

Requires group health plans and health insurance insurers to maintain a “price comparison tool” available via phone and website that allows enrolled individuals and participating providers to compare cost-sharing amounts for items and services furnished by any participating provider.

#### Implementation Status

- On August 20, 2021, federal agencies released [guidance](#) delaying the effective date for these new tools by one year, from January 1, 2022, to January 1, 2023.
- Enforcement of this requirement has been deferred until at least January 1, 2023, while federal agencies determine whether the No Surprises Act price comparison tool requirements can be met by other tools already under development for future implementation. In the meantime, our existing cost estimate and price comparison tools will continue to be available to all our members to assist with their evaluation of potential out-of-pocket costs for covered services.

# Air Ambulance Reporting

## Section 106

### Effective March 31, 2023

#### Overview

- Requires group health plans and insurers to submit two years of claims data related to air ambulance services to the Secretary of HHS.
- The claims-level data elements group health plans and insurers must submit include:
  - Insurer or plan sponsor name;
  - Market type of the plan or coverage associated with the air ambulance services;
    - For fully insured coverage, this would include the individual, small group, and large group markets.
    - For self-insured group health plans, this would include identification of the plan sponsor as a small employer or large employer.
  - The date of service;
  - Billing NPI and Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes information;
  - Information about each air ambulance transport (such as the loaded miles and whether the transport was an inter-facility transport);
  - Claim adjudication information (including whether the claim was paid, partially paid, denied, or appealed, and the reason for the denial and the outcome of the appeal, if applicable); and
  - Claim payment information (including submitted charges, amounts paid by the payor, and cost-sharing amount).

#### Implementation Status

- On September 16, 2021, federal agencies released a [proposed rule](#) related to the implementation of these reporting requirements.
- The proposed rule indicates that insurers would be required to submit claims data for calendar year 2022 by March 31, 2023, and submit data for calendar year 2023 by March 30, 2024.
- Once this rulemaking is completed, we will provide more details on these reporting requirements and outline how we will support our group clients based on those rules.



**Provisions Deferred Until  
New Rulemaking  
Completed**



## Advance EOBs

### Effective TBD

#### Overview

- Requires individual and group health plans to provide an Advance Explanation of Benefits (EOBs) for scheduled services at least three days in advance to give patients transparency into:
  - Which providers are expected to provide treatment;
  - The network status of providers involved in the treatment/service;
  - The good faith estimates of cost, cost-sharing, and patient progress toward meeting deductibles and out-of-pocket maximums;
  - Whether a service is subject to medical management protocols; and
  - Any relevant disclaimers related to these estimates.
- The Advance EOB must be provided to the patient in either electronic or paper form based on their communication preferences.
- The Advance EOB requirement is triggered upon notification from the provider of the scheduled service to the insurer, or upon request of the patient (or their authorized representative).

#### Implementation Status

*Important:* On August 20, 2021, federal agencies released [guidance](#) delaying the implementation of the following provisions until the completion of new rulemaking. Additional information will be provided as it becomes available.



## Good Faith Estimate for Insured Patients

### Effective TBD

#### Overview

- Requires providers and facilities to verify, three days in advance of service, and not later than one day after scheduling of service, what type of coverage the patient is enrolled in and to provide notification of a good faith estimate to the payer (if the patient is enrolled in a plan or insurance coverage and intends to use such coverage) or patient.
- Requires providers to provide information on service and billing codes to health plans or directly to the individual for uninsured.

#### Implementation Status

*Important:* On August 20, 2021, federal agencies released [guidance](#) delaying the implementation of the following provisions until the completion of new rulemaking. Additional information will be provided as it becomes available.





# Machine Readable Files for Prescription Drugs

## Effective TBD

### Overview

- The Transparency in Coverage final rules require non-grandfathered group health plans and insurers offering non-grandfathered coverage in the group and individual markets to disclose information in three separate machine-readable files:
  - 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.
- These files must be posted on a publicly available website and updated monthly.

### Implementation Status

*Important:* On August 20, 2021, federal agencies released [guidance](#) delaying the implementation of the following provisions until the completion of new rulemaking. Additional information will be provided as it becomes available.



## Next Steps

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Review the information in this document so that you are prepared to answer questions from external stakeholders if you are asked about Florida Blue or Truli for Health's preparations to comply with these new requirements.