Departments Delay Enforcement of Transparency Disclosure Requirements

Insights
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Group health plan sponsors soon will face daunting new disclosure and transparency requirements under multiple laws including the Affordable Care Act (ACA), the No Surprises Act (the Act) and the Consolidated Appropriations Act, 2021 (CAA). The various rules overlap and potentially conflict in some areas. Accordingly, the U.S. Departments of Health and Human Services, Labor, and Treasury recently issued FAQ guidance specifically to help plan sponsors understand their duties under the final Transparency in Coverage Rules (TiC Final Rules) issued under the ACA and similar provisions in the CAA. The FAQ also extend the deadlines (as noted in italics below) by which plan sponsors must comply with the rules.

Background

Under the TiC Final Rules, non-grandfathered group health plans must disclose on a public website information about in-network and out-of-network provider rates, allowed amounts and billed charges, negotiated rates, and historical pricing for covered prescription drugs. These rules will require plan sponsors to develop three separate machine-readable files to post for plan years beginning on or after January 1, 2022. The Departments issued the TiC Final Rules before Congress passed the CAA and, unfortunately, the CAA drafters did not fully reconcile the newer requirements (which also apply to grandfathered plans) with those already set by the ACA.

Prescription Drug Pricing

The Departments understand that the CAA contains transparency rules regarding plan sponsors' prescription drug reporting. Because the two sets of rules could lead to duplication and waste, the Departments will delay enforcement of the TiC Final Rule on publishing machine-readable files regarding prescription drug pricing until they issue additional final rules. *Thus, non-grandfathered plan sponsors will not have to publicly publish such information by January 1, 2022.*

The CAA also requires plan sponsors to submit to the Departments information regarding prescription drug expenses that includes:

- general plan year dates;
- enrollment census information; and

- specific detail regarding the 50 most frequently dispensed drugs, the 50 most expensive drugs, and the 50 drugs with the greatest year-to-year increase in expense.

Plans also must report average monthly premiums, prescription drug expenditures and the impact of any prescription drug manufacturer rebates on expenditures. *The Departments stated that they will provide forthcoming final regulations and will not enforce these provisions until then. However, the Departments encourage plans to ready themselves to report 2020 and 2021 information by December 27, 2022.*

Network Details

Citing again the potential overlap and conflict between the TiC Final Rules and the CAA transparency provisions, the Departments have announced that they will not enforce the TiC Final Rule requiring public disclosure of in-network rates and out-of-network allowed amounts until July 1, 2022. *So, non-grandfathered plan sponsors will have an additional six months to develop compliant materials to address this mandate. New plans that begin after July 1, 2022 must post appropriate machine-readable files in the month in which the plan year starts.*

Price Comparison Tool

The TiC Final Rules require non-grandfathered plans to adopt and issue (via internet portal or, if requested, in writing) a price comparison tool to allow participants to price shop 500 items and services identified by the Departments for plan years beginning on or after January 1, 2023. Plan sponsors must expand the tool to cover items and services for plan years beginning on or after January 1, 2024. Not surprisingly, the CAA also requires non-grandfathered and grandfathered plans to provide price comparison guidance beginning with plan years starting on or after January 1, 2022 – one year sooner than under the TiC Final Rules. *The Departments will not enforce price comparison rules under the CAA or TiC Final Rules until plan years beginning on or after January 1, 2023.*

Insurance Cards

The CAA requires plans and carriers to enhance health plan identification cards by including deductible and out-of-pocket maximum information. Further, for plan years beginning on or after January 1, 2022. identification cards will need to list a telephone number and website address for individuals to get further information. *The Departments intend to provide future guidance on identification card disclosure. Until then, plans and issuers should use reasonable efforts to comply.*

For example, reasonable efforts could include disclosing the major medical deductible and out-of-pocket maximum information along with a phone number and website address to get other deductible and out-of-pocket maximum information. The Departments also state that plans could make additional information available through a QR code (if hard copy) or hyperlink (if electronic).

Advance Explanation of Benefits

Beginning with plan years starting on or after January 1, 2022, the CAA dictates that providers must give individuals good faith estimates of the costs for services and any items expected to be provided when they schedule services or request an estimate. The CAA further requires plans to provide an advance explanation of benefits based on service providers' good faith estimates. *The Departments will not enforce the provisions as to plan sponsors until they publish future final rules.*

Accurate Provider Directory Information

The CAA requires plans to provide accurate provider directories and to update them regularly to keep them accurate. The CAA further requires plans to respond to participant and beneficiary requests about provider network status. If an individual receives services from an out-of-network provider or facility but had received incorrect information in a provider directory that the provider or facility was in-network, the plan must limit charges to the in-network levels. *The Departments intend to issue final rules regarding this requirement but will not do so until after January 1, 2022. The Departments expect plans to use good faith efforts to comply until final rules issue.* In the interim. the Departments will not penalize plan sponsors who limit cost-sharing amounts to no more than in-network levels for any out-of-network services or items received by a covered individual who received incorrect network status information in a provider directory.

Conclusion

The FAQ provides welcome relief (and more time) to plans facing deadlines to comply with burdensome new disclosure and reporting obligations. Plan sponsors should be sure they understand these requirements and take reasonable steps to comply in good faith until the Departments provide further guidance.

We will monitor these developments and provide updates as warranted, so make sure that you are subscribed to Fisher Phillips' Insights to get the most up-to-date information direct to your inbox. If you have further questions, contact your Fisher Phillips attorney, the author of this Insight, or any attorney in our Employee Benefits and Tax Practice Group.

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