Departments Defer Transparency and Disclosure Rule Enforcement, Provide FAQ Guidance

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On August 20, 2021, the U.S. Departments of Health and Human Services, Labor, and Treasury (collectively, the Departments), issued FAQ guidance regarding provisions of the Affordable Care Act (ACA), the No Surprises Act (the Act) and the Consolidated Appropriations Act, 2021 (CAA). Specifically, the FAQ provide guidance to group health plans and health insurance carriers to help them comply with the final Transparency in Coverage Rules (TiC Final Rules) issued under the ACA and similar provisions in the CAA. This Advisor provides a high-level summary of the FAQ and its impact on employer plan sponsors.

Background

The TiC Final Rules require non-grandfathered group health plans and health insurance issuers that offer non-grandfathered group or individual coverage to disclose on a public website information about 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 pricing for covered prescription drugs. Disclosures must be in the form of three separate machine-readable files and must be posted for plan or policy years beginning on or after January 1, 2022. The CAA also contains notice and disclosure requirements as discussed below. The Departments have clarified that the CAA provisions will apply equally to grandfathered health plans.

Prescription Drug Pricing Disclosure

The Departments finalized the TiC Final Rules before Congress passed the CAA. The Departments understand that the CAA also contains transparency rules that will impose on plan sponsors and carriers certain transparency requirements for prescription drug reporting. Because the two sets of rules could lead to duplicate reporting, the Departments will delay enforcing the TiC Final Rule on publishing machine-readable files regarding prescription drug pricing until they have issued further final rules on the subject. Thus, non-grandfathered plan sponsors will not be deemed to have violated the TiC Final Rules if they do not publicly publish such information by January 1, 2022.

Prescription Drug Pricing Disclosure to the Departments

The CAA requires plan sponsors and carriers to submit to the Departments information regarding prescription drug expenses including 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 plan expense. Plans also must report information on average monthly premiums, prescription drug expenditures and the impact of any prescription drug manufacturer rebates on expenditures including any reduction in premiums and out-of-pocket costs. The Departments intend to issue final regulations addressing these reporting requirements and will not enforce these provisions until they do. Thus, plans will not need to report this information by originally stated deadlines. The Departments encourage plans to prepare for and be ready to report data for 2020 and 2021 by December 27, 2022.

In-network and Out-of-network Information

Again because of potential overlap and conflict between the TiC Final Rules and the CAA transparency provisions, the Departments will defer their enforcement of the TiC Final Rule requiring public disclosure of in-network rates and out-of-network allowed amounts and billed charges until July 1, 2022. So, non-grandfathered plan sponsors will not be deemed to have violated this rule if they do not publish such information before July 1, 2022. Plans that begin after July 1, 2022, must post appropriate machine-readable files in the month in which the plan year begins.

Price Comparison Tool

The TiC Final Rules require non-grandfathered plans to implement an internet-based self-service tool (and in paper form by request) to allow participants and beneficiaries to be able to compare prices for 500 items and services identified by the Departments for plan years beginning on or after January 1, 2023, and for all covered items and services for plan years beginning on or after January 1, 2024. 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. Due to the conflict between the two sets of rules regarding price comparison information, 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 Card Transparency

The CAA requires plans and carriers to include on any physical or electronic plan identification card applicable deductible and out-of-pocket maximum information. Identification cards also must include a telephone number and website address for individuals to get further information starting with plan years beginning on or after January 1, 2022. Because this information can be complex based on certain plan designs, the Departments intend to provide future guidance on identification card disclosure. In the meantime, plans and issuers should use good faith effort and reasonable interpretation to comply with this requirement. For example, the Departments would deem an identification card that disclosed the major medical deductible and out-of-pocket maximum information along with a telephone number and website address to obtain other deductible and out-of-pocket maximum information to be a good faith effort to comply. The Departments note that plans and carriers could make additional information available through a QR code (or hyperlink on an electronic identification card).

Advance Explanation of Benefits

The CAA requires health care providers, starting with respect to plans beginning on or after January 1, 2022, to provide individuals with good faith estimates of the costs for services and any items expected to be provided when individuals schedule services or request an estimate. The CAA further requires plans to provide an advance explanation of benefits based on the service provider's good faith estimate. The Departments will not enforce the provisions requiring an advance explanation of benefits until they issue intended final rules on the subject.

Gag Clause Prohibition

The CAA prohibits plans and carriers from agreeing to restrict disclosure or agreeing not to disclose provider-specific cost and quality of care information, to prevent electronic access to such information, or to forbid sharing such information subject to applicable privacy rules. Plans will need to annually attest to the Departments that they have not entered any such agreement. The Departments advise that plans must use good faith efforts to comply with this rule and that the Departments intend to issue further guidance on the form of the attestations and how they will collect them beginning in 2022.

Accurate Provider Directory Information

The CAA requires plans to provide accurate provider directories and to keep them periodically updated to ensure their ongoing accuracy. The CAA further requires plans to create a process to respond to participant and beneficiary telephonic or electronic requests about provider network status. Plans will be required to limit charges to those for in-network services if a participant 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 Departments intend to issue final rules regarding this requirement but will not do so until after January 1, 2022. The Departments expect plans and carriers to use good faith efforts to comply until final rules issue. The Departments will not deem a plan to have violated the rule if it imposes cost-sharing amounts no greater than the amounts for in-network providers or services for any out-of-network services or items received when a participant or beneficiary had received inaccurate provider information in a provider directory that the provider or facility was in-network.

Continuity of Care

The CAA requires plans and providers to ensure that participants and beneficiaries can continue to receive care or treatment from the same providers and facilities during a course of treatment under the same terms and conditions for 90 days following certain contractual changes that change the status of a provider or facility from in-network to out-of-network during the course of treatment, during pregnancy or related to a scheduled elective surgery. The Departments plan to issue future final rules on this requirement that will include a prospective applicability date. Until then, the Departments expect plans and carriers to use good faith and reasonable efforts to comply.

Conclusion

The FAQ guidance provides welcome relief for plans that were facing a looming deadline to comply with conflicting and overlapping disclosure and reporting obligations. This guidance will afford plan sponsors more time and more detailed future guidance to meet their obligations in this area. However, plan sponsors should be sure they understand these requirements and must take reasonable steps to comply in good faith until the Departments provide further guidance.

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