CLIENT ALERT

DOL Extends Certain Deadlines Under the CAA and Transparency in Coverage Rules

DOL Extends Certain Deadlines Under the CAA and Transparency in Coverage Rules

In October 2020, CMS Released its Transparency in Coverage Final Rules (the "TiC Final Rules") which require non-grandfathered group health plans and carriers offering health insurance in the individual and group markets to: (1) make available to the public three separate machine-readable files (for in-network rates, out-of-network allowed amounts, and prescription drugs) that include detailed pricing information for each available coverage option, and (2) release cost-sharing information to participants, including the underlying negotiated rates, for all covered health care items and services, including prescription drugs, through an internet-based self-service tool and in paper form (upon request).

The TiC Final Rules were intended to be rolled out over a three-year period beginning January 1, 2022; however, in August 2021, the DOL released FAQs that delay implementation until July 2022 or later.

In addition to the deadline extensions for the TiC Final Rules, certain other new transparency requirements authorized under the Consolidated Appropriations Act, 2021 (CAA) that were scheduled to become effective later this year are delayed pursuant to the FAQs. The transparency requirements of the TiC Final Rules and the CAA, along with the deadline extensions, are summarized in more detail below. Additionally, the TiC Final Rules are currently in the process of being litigated in federal district court.

Transparency in Coverage Final Rules

In October 2020, CMS released the TiC Final Rules, which require group health plans and health insurance carriers ("carriers") to publicly post standard charge information and negotiated rates for common shoppable items and services in an easy-to-understand, consumer-friendly, and machine-readable format. Regulations were also ordered to be implemented for hospitals to post (and regularly update) standard charge information for services, supplies, or fees billed to patients, or provided by hospital employees. The hospital requirements were effective beginning January 1, 2021, while the TiC Final Rules are effective for plan years beginning on or after January 1, 2022, except as delayed below. The TiC Final Rules are summarized below, followed by the extensions.

Machine Readable Files

Under the TiC Final Rules, for plan years beginning on or after January 1, 2022, most non-grandfathered group health plans and insurance carriers offering non-grandfathered health insurance coverage in the individual or group markets are required to make available to the public, including stakeholders such as consumers, researchers, employers, and third-party developers, three separate machine-readable files that include detailed pricing information. The information must be available on an internet website. Specifically, three separate machine-readable files for "each coverage option offered by a group health plan or health insurance issuer" must be created – one for in-network rates, one for out-of-network allowed amounts, and one for prescription drugs.

The information required to be included in each machine-readable file for all covered items and services are described in the regulations.

The machine-readable files must be updated monthly (and clearly indicate the date the file was last updated) and must be available in a form and manner specified in any guidance issued by the IRS, DOL, or CMS. Further they must be publicly available and accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file.

An aggregated allowed amount for more than one plan or insurance policy or contract is permitted for out-of-network ("OON") allowed amounts where the group health plan or carrier contracts with a carrier, service provider, or other party to provide the information. This may be hosted on a third-party website or posted by a third party; however, the group health plan or carrier must provide a link to the site hosting or post the information on its own website.

Release of Cost-Sharing Information to Participants and Beneficiaries

Additionally, for plan or policy years beginning on or after January 1, 2023, upon request, a plan is required to provide to participants and beneficiaries enrolled in the group health plan, cost sharing information for the 500 covered items and services identified in Table 1 of the TiC Final Rules (all other covered items and services must be provided for plan or policy years beginning on or after January 1, 2024) in a format described in the regulation.

Plans and carriers must provide the required information on an internet-based self-service tool that meets certain requirements, or via hardcopy/paper format upon request. There can be no cost for the information, and the information must be provided in plain language. The plan or issuer may limit the number of providers to no fewer than 20 providers per request and meet certain timing, content, and delivery requirements.

Fully insured group health plans can contract (in writing) with the carrier to provide any of the above-described information (machine-readable files, paper files, or internet information to participants or beneficiaries) on behalf of the plan. In those circumstances the issuer, not the group health plan, is responsible for compliance and any compliance failures. Self-funded plans can contract with a third-party administrator or other party to assist the plan with compliance; however, the self-funded group health plan ultimately remains responsible for compliance and any compliance failures on the part of the TPA or other party. Additionally, group health plans and health insurance carriers are required to comply with any state or federal privacy laws when complying with any of the above-described disclosure requirements.

Deadline Delays for Transparency in Coverage Rules

With many of the deadlines under the TiC Final Rules as well as other transparency requirements under the CAA fast approaching, the DOL released FAQ #49, extending certain deadlines.

Machine Readable Files

The deadline for machine readable files for in-network rates and OON allowed amounts and billed charges for covered items and services is extended from January 1, 2022 to July 1, 2022. The agencies intend to release more guidance prior to the deadline.

Further, the deadline to provide machine readable files for prescription drugs is delayed indefinitely. This requirement has clear overlap with transparency requirements under the Consolidated Appropriations Act, 2021. Accordingly, the DOL intends to consider whether prescription drug machine-readable file requirements are appropriate and will address this through notice-and-comment rulemaking.

States are required to enforce the machine-readable file requirements for carriers, so the DOL encourages states to take a similar approach and delay enforcement of the machine-readable file requirements for in-network rates, OON allowed amounts, and prescription drugs using the same timeframes.

Release of Cost-Sharing Information to Beneficiaries and Participants

The CAA, 2021, which was passed after the TiC Final Rules, includes largely duplicative requirements for group health plans and insurance carriers to provide cost-sharing information to participant and beneficiaries, and further requires price information to be provided via telephone upon request (in addition to online or paper requirements). To address the duplicative nature of these requirements, the agencies intend to propose rulemaking to require the same pricing information available through the online tool (or by paper upon request) be provided by telephone (upon request) as well. Further, the agencies will defer enforcement of any CAA requirements under the CAA until plan years beginning on or after January 1, 2023 (which is consistent with the first compliance deadline under the TiC Final Rules).

States are required to enforce these requirements for carriers, so the DOL encourages states to take a similar approach and delay enforcement of these requirements until plan years beginning on or after January 1, 2023.

Other Transparency-Related Deadlines Extended

Pharmacy Benefits and Drug Costs Reporting Under the CAA

The CAA requires group health plans or carriers to begin reporting detailed information regarding the plan and its coverage of certain prescription drugs (the 50 brand prescription drugs most frequently dispensed and the 50 prescription drugs with the greatest increase in plan expenditures over the plan year) as well as other plan information beginning on December 27, 2021, and each June 1st thereafter. The DOL recognizes the significant operational challenges plans and carriers may encounter complying with these reporting requirements by the applicable statutory deadline and, therefore, the DOL has deferred enforcement of the first and second reporting deadlines by one year. Therefore, plans will be required to file their first report on December 27, 2022, and each June 1st thereafter. The agencies encourage plans and carriers to amend contracts and put processes and procedures in place to ensure they can meet the initial December 27, 2022 deadline.

Advanced Explanation of Benefits (Advanced EOBs)

Effective for plan years beginning on or after January 1, 2022, upon receiving a good faith estimate regarding certain items or services, the CAA requires group health plans and carriers to send (via mail or electronically) a participant, beneficiary, or enrollee an Advanced EOB in clear and understandable language that includes certain specified information, including (1) the network status of the provider or facility, (2) the contracted rate (for participating providers or facilities) or a description of how a participant can obtain information about participating providers or facilities, (3) good faith estimate received from the provider or facility, (4) a good faith estimate of the participant's cost-sharing and the plan's responsibility for paying for the items or services, and (5) information regarding any medical management techniques that apply to the items or services. The Advanced EOB must clearly state it is only an estimate based on the items or services reasonably expected to be provided at the time of scheduling/requesting the item or service and is subject to change based on the items or services actually provided.

Due to the complexity of these requirements, the technological requirements involved, and the lack of agency guidance on these requirements, the DOL intends to engage in notice-and-comment rulemaking in the future to implement these requirements, including establishing appropriate data transfer standards. Accordingly, the DOL will defer enforcement, but did not specify a specific compliance date.

HHS intends to explore whether interim solutions are feasible for insured consumers and encourages states to delay enforcement of these requirements for applicable plans.

Other Transparency-Related Guidance Addressed in the FAQs

In other instances, the DOLs FAQs do not extend the deadline to comply with certain transparency requirements under the CAA; they provide certain enforcement guidance or clarification. This information is summarized below:

Insurance ID Cards

Effective for plan years beginning on or after January 1, 2022, the CAA requires plans and carriers to include on any physical or electronic plan or insurance identification card issued to participants, beneficiaries, or enrollees any applicable deductibles, out-of-pocket maximum limitations, and a telephone number and website address for consumers seeking consumer assistance. The information is required to be provided in clear writing.

The agencies do not intend to issue rules related to this requirement before January 1, 2022, and, therefore, plans and carriers must begin to comply with these requirements by that date. Plans and carriers are expected to determine how to represent plan and coverage designs in a compliant way on the ID cards using a good faith, reasonable interpretation of the law. Reasonable methods may be varied, and agencies will consider whether the approach used by the plan or issuer is reasonably designed and implemented to provide the required information to all participants, beneficiaries, and enrollees. Agencies will consider whether the specific data elements are included or, if not, whether it is made available through other information that is provided on the ID card and the mode by which any information absent from the card is made available, when required information is made available. Per the agencies, a compliant ID card could include the applicable major medical deductible and applicable out-of-pocket maximum, as well as a telephone number and website address for individuals to seek consumer assistance and access additional applicable deductibles and maximum out-of-pocket limits, the card could include a QR code or link (if the card is digital) to access additional deductible out-of-pocket maximum limits for the plan.

Gag Clauses

Pursuant to the CAA, since December 27, 2020, providers, networks or associations of providers, TPAs, or other service providers have been prohibited from either directly or indirectly restricting (by agreement) plans or carriers from (1) providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage; (2) electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee; and (3) sharing such information (in compliance with any privacy regulations). Further, plans and carriers are required to submit an annual report to the DOL, HHS, or IRS confirming compliance with these requirements.

The DOL believes these requirements are self-implementing and does not expect to issue any regulations on these requirements, though they will release guidance regarding how to submit attestations of compliance beginning in 2022. Therefore, unless and until any guidance is released, plans and carriers must comply with these requirements using a good faith, reasonable interpretation of the statute.

Provider Directory

The CAA established provider directory standards, which require plans or carriers to establish a process for updating and verifying the accuracy of information in their provider directories, and establish a protocol for responding to telephone calls and electronic communications from participants, beneficiaries, or enrollees about a provider's network participation status, and must honor any incorrect or inaccurate information provided to the participant, beneficiary, or enrollee about the provider's network participation status.

While the DOL intends to initiate rulemaking on these requirements sometime in 2022, the deadline for compliance is not extended. Plans and carriers must comply with these requirements, and will not be considered to be out of compliance if, (1) beginning on or after January 1, 2022, in situations where a participant, beneficiary, or enrollee receives items and services from a non-participating provider and the individual was provided inaccurate information by the plan or issuer via the provider directory or response protocol indicating the provider was participating, and (2) the plan or issuer imposes only a cost-sharing amount that is not greater than the cost-sharing amount that would be imposed for items and services furnished by a participating provider, and counts those cost-sharing amounts toward any deductible or out-of-pocket maximum. Once implemented, the final rules will have a prospective effective date.

Balance Billing Disclosure Requirements

The balance billing disclosure requirements of the No Surprises Act are effective for plan years beginning on or after January 1, 2022. In the preamble to its interim final rules addressing balance billing, the DOL indicated that it intends to address balance billing disclosure requirements in more detail in the future; however, that may not occur before January 1, 2022. Accordingly, plans and carriers must comply with these requirements using a good faith, reasonable interpretation of the statute for plan years beginning on or after January 1, 2022. Once implemented, the final rules will have a prospective effective date. In the meantime, the DOL issued a model disclosure notice that may be used to satisfy the disclosure requirements regarding the balance billing protections.

Continuity of Care Requirements

The CAA requires group health plans or carriers to establish certain continuity of care protections when there are changes in provider or facility networks under the plan effective for plan years beginning on or after January 1, 2022. While the DOL intends to initiate rulemaking on these requirements sometime in 2022, the deadline for compliance is not extended. Plans and carriers must comply with these requirements using a good faith, reasonable interpretation of the statute for plan years beginning on or after January 1, 2022. Once implemented, the final rules will have a prospective effective date.

What's Next for Employers?

While employers have been given an extension for complying with many of the provisions of the Transparency in Coverage regulations and transparency-related provisions of the CAA, plans should follow the DOL's suggestion and ensure they update any contractual provisions with their TPAs or carriers and identify which parties are responsible for preparing any machine-readable files or other deliverables under these new statutory and regulatory requirements. Group health plan sponsors, including sponsors of grandfathered health plans with regard to the No Surprises Act and other applicable requirements, should continue to monitor additional rulemaking or guidance issued by the agencies related to any transparency provisions.

About The Authors. This alert was prepared for Manquen Vance by Marathas Barrow Weatherhead Lent LLP, a national law firm with recognized experts on the Affordable Care Act. Contact Peter Marathas or Stacy Barrow at pmarathas@marbarlaw.com or sbarrow@marbarlaw.com.