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Some Transparency in Coverage and CAA Deadlines Delayed

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Issued date: 09/02/21

On August 20, 2021, the Departments of Health and Human Services ("HHS"), Labor ("DOL"), and the Treasury (collectively called "the Departments") jointly issued an FAQ which implements parts of the Consolidated Appropriations Act ("CAA") that was passed at the end of 2020 and the Transparency in Coverage ("TiC") final regulations that were issued in November of 2020. The requirements under the CAA apply to all group health plans, including grandfathered plans.

The FAQ defers enforcement of certain provisions of the CAA and TiC regulations, including:

- TiC – Machine Readable Files:
  - For files associated with in-network rates and out-of-network allowed amounts and billed charges, delayed until July 1, 2022.
  - For prescription drug files, delayed pending future guidance.
- CAA Price Comparison Tools: Delayed until the first plan year that begins on or after January 1, 2023 (to align with TiC requirements).
- Good Faith Estimate ("GFE") and Advance Explanation of Benefits ("EOBs"):
  - Delayed pending future rulemaking.
- Reporting on Pharmacy Benefits and Drug Costs:
  - Delayed pending future rulemaking – compliance expected by December 27, 2022.

Other provisions of the CAA will continue to take effect as described under the statute, but with good faith relief available pending future guidance or rulemaking. The following describes each requirement and any available relief.

Transparency in Coverage – Machine Readable Files

Requirement: Group health plans and health insurance carriers must make public three machine-readable files disclosing:

1. in-network rates,
2. out-of-network ("OON") allowed amounts and billed charges, and

3. negotiated rates and historical net prices for covered prescription drugs.

Originally, group health plans were to comply with this requirement for plan years beginning on or after January 1, 2022.

Enforcement Relief: FAQ 49 provides the following relief with respect to publishing machine readable files:

- The requirement to make public in-network rates and OON allowed amounts and billed charges (1 and 2 above) is delayed until July 1, 2022.
  - For plan years that begin between January 1, 2022 and July 1, 2022, the files must be posted by July 1, 2022.
  - For plan years that begin after July 1, 2022, the files must be posted in the month in which the plan year begins.

- The requirement to make public negotiated rates and historical net prices for covered prescription drug (3 above) has been delayed pending further rulemaking.

Transparency in Coverage – Price Comparison Tools (Including CAA Requirements)

Requirement: Under the TiC requirements, group health plans and carriers must provide for the disclosure of cost sharing information in advance of receiving care. Such disclosure is required to be made through an internet-based self-service tool and in paper form. This requirement takes effect for plan years beginning on or after January 1, 2023, with respect to 500 identified items and services. Full compliance is required for plan years beginning on or after January 1, 2024.

The CAA includes price transparency and cost information requirements that are similar to (if not duplicative of) what is required by the TiC. Under the statute, the CAA requirements take effect for plan years beginning on or after January 1, 2022.

Enforcement Relief: The Departments will delay enforcement of the CAA's price comparison requirement to align with the TiC effective date (plan years beginning on or after January 1, 2023). In addition, the Departments will undertake rulemaking to determine whether the requirements from the TiC final rules also satisfy the requirements of the

CAA. Notably, future guidance will require that cost sharing information be available via telephone (as well as through the internet and in paper form). Plans with existing tools should continue to make them available.

While the TiC requirements do not apply to grandfathered plans, to the extent they are duplicative of requirements under the CAA, grandfathered plans will likely need to comply.

Insurance ID Cards

Requirement: The CAA requires plans and carriers to include on any physical or electronic ID cards information about deductibles, out-of-pocket maximums, and a telephone number and website address for individuals to seek consumer assistance. Group health plans must comply with this requirement for plan years beginning on or after January 1, 2022.

Good Faith Relief: While regulations are expected to implement the ID card requirements, they will not be issued until after January 1, 2022. Plans should continue to implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute.

Good Faith Estimate and Advance Explanation of Benefits

Requirement: The GFE and Advance EOB requirements under the CAA go hand in hand. Upon the scheduling of items or services (or upon patient request) providers are required to:

- inquire whether the individual has health insurance coverage, and
- provide a GFE of the expected charges for furnishing those items and services to the group health plan.

Upon receiving a GFE, the group health plan must send the participant or beneficiary an Advance EOB that includes certain prescribed information. Originally, group health plans were to comply with this requirement for plan years beginning on or after January 1, 2022.

Enforcement Relief

The Departments are delaying enforcement until future guidance is issued. Any future guidance will include a prospective applicability date to provide additional time for compliance.

Prohibition on Gag Clauses on Price and Quality Data

Requirement: Plans and carriers may not enter into an agreement with a provider, network, TPA or other service provider offering access to a network of providers that directly (or indirectly) restricts the plan from:

- furnishing provider-specific cost or quality of care information or data;
- electronically accessing de-identified claims and encounter data for each participant or beneficiary; and
- sharing such information, consistent with applicable privacy regulations.

Plans and carriers must submit an attestation of compliance.

This requirement was effective December 27, 2020.

Good Faith Relief: Plans should implement this requirement using a good faith, reasonable interpretation of the statute. Future guidance is expected as to how plans will complete and submit the required attestation. This attestation process is expected to begin in 2022.

Provider Directories

Requirement: Group health plans must update and verify the accuracy of provider directory information (every 90 days) and establish a protocol for responding to requests by telephone and email from a member about a provider's network participation status.

If a participant or beneficiary is furnished an item or service by a non-participating provider (or facility) and the individual was provided inaccurate directory information that stated the provider was "in-network", the plan must generally treat the item or service as provided in-network.

Group health plans should comply with this requirement for plan years beginning on or after January 1, 2022.

Good Faith Relief: Regulations are expected, but not until after January 1, 2022. Plans should continue implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute.

The Departments have stated that plans will not be out of compliance if they do not impose more than in-network cost-sharing and count any cost-sharing toward the in-network deductible and out-of-pocket maximum in situations where the participant is provided information stating that a provider is in-network.

Balance Billing Disclosure

Requirement: The CAA requires plans and carriers to make certain disclosures regarding balance billing protections to participants and beneficiaries. This notice requirement is effective for plan years beginning on or after January 1, 2022.

Good Faith Relief: Regulations are expected, but not until after January 1, 2022. Plans should continue implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute. Plans will not be out of compliance when using the model notice (as appropriately modified).

Requirement: For plan years beginning on or after January 1, 2022, a patient in a course of treatment with an in-network provider/facility that becomes OON must be notified and given an opportunity to receive coverage on the same terms for up to 90 days.

Good Faith Relief: Regulations are expected, but not until after January 1, 2022. Plans should continue implement this provision effective with the first plan year that begins on or after January 1, 2022, using a good faith, reasonable interpretation of the statute. Any future rulemaking will apply prospectively allowing plans and carriers a reasonable time to comply.

Reporting on Pharmacy Benefits and Drug Costs

Requirement: Group health plans and carriers must submit a report to the Departments with respect to certain health plan and prescription drug information based on the previous plan year. Notably, the 50 most common brand dispensed prescriptions, the 50 most costly drugs, and the 50 drugs with the greatest year-over-year costs. This is in addition to other information including the impact of rebates on premiums and out-of-pocket costs.

Enforcement Relief: Recognizing the significant operational challenges with this requirement, the Departments will defer enforcement for both the first and second deadlines (December 27, 2021 and July 1, 2022, respectively) pending the issuance of regulations or further guidance.

Plans should work to ensure they are able to comply with 2020 and 2021 information reporting by December 27, 2022.

Employer Action

As many of these provisions are a function of plan administration, it will be important to consult carriers and TPAs (and PBMs with respect to pharmacy reporting) to understand their capabilities to assist in compliance with these new requirements. While the delayed timeframes are helpful, it will be important to understand the provisions and timeframe for when the requirements apply to your group health plan.