HAYS COMPANIES

Guidance On Health Plan Transparency Rules Delays Some Compliance Dates

On August 20, 2021, the DOL, IRS, and HHS (the "agencies") issued FAQs (available here) addressing a number of the health plan transparency requirements found in the final regulations issued under the ACA last October and in the No Surprises Act, which was enacted in late December 2020. For reference, please review our prior articles regarding the final transparency regulations and the No Surprises Act.

The FAQs provide some welcome relief for plan sponsors, as several compliance dates have been delayed. The FAQs also appear to confirm the agencies' intent to combine the ACA transparency requirements with the No Surprises Act for compliance purposes.

Note: In large part, the FAQs are most applicable to self-insured plans because states have the authority to enforce many of the transparency requirements against issuers of group health insurance policies. However, the FAQs indicate that HHS is encouraging states that are primary enforcers of these requirements for issuers to take a similar enforcement approach and will not determine a state is failing to substantially enforce this requirement if it takes such an approach.

The key takeaways for sponsors of group health plans are:

Publicly Available Machine-Readable Files

The final transparency regulations require most group health plans to make available on a public website machine-readable files containing data regarding 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. The regulations require these files to be posted by the first day of the first plan year, beginning on or after January 1, 2022. According to the FAQs, group health plans will have longer to comply with these requirements as follows:

- The files containing data on in-network provider rates for covered items and services and out-of-network allowed amounts and billed charges for covered items and services now must be posted by the later of ***July 1, 2022*** (for plans with plan years beginning between January 1 and July 1, 2022) or the first day of the 2022 plan year.
- Enforcement of the requirement to make available the file containing data on negotiated rates and historical net prices for covered prescription drugs is ***delayed indefinitely*** while the agencies revisit the need for such files in light of prescription drug reporting requirements contained in the No Surprises Act.

Price Comparison Information

The final regulations and the No Surprises Act include provisions requiring group health plans to make available price comparison information to individuals covered under the plan. While the two requirements are similar, there are some differences. Furthermore, the No Surprises Act requirements are effective as of the first day of the first plan year beginning on January 1, 2022, while the requirements of the final regulations are not first effective (in part) until 2023. According to the FAQs:

- The agencies are delaying enforcement of the price comparison requirements of the No Surprises Act until the first day of the first plan year beginning on or after January 1, 2023.
- The agencies intend to amend the final transparency regulations to require group health plans to make price comparison information available by telephone (which is required under the No Surprises Act provision).
- The agencies will evaluate whether compliance with the price comparison requirements of the final transparency regulations constitutes compliance with the corresponding requirements of the No Surprises Act.

Health Plan ID Card Requirements

Under the No Surprises Act, health plan ID cards must include certain information beginning in the first plan year beginning on or after January 1, 2022. The compliance date of this requirement ***is not*** being delayed. However, the agencies will not release any implementation guidance regarding this requirement before January 1, 2022. Accordingly, pending future rulemaking, plans are expected to implement the ID card requirements using a good faith, reasonable interpretation of the law. The FAQs include some additional information regarding good faith approaches.

Advanced Explanation of Benefits

The FAQs indicate the agencies will not enforce the No Surprises Act's requirement that group health plans issue advanced explanation of benefits in certain circumstances until future rulemaking implementing this requirement is completed.

Prohibition on Gag Clauses

The compliance date of the provision of the No Surprises Act prohibiting the inclusion of gag clauses in agreements with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan from gaining access to certain information ***is not*** being delayed. Furthermore, the agencies believe there is no need for regulations to implement the substantive requirement. However, the agencies will be issuing guidance regarding the procedures for submitting attestations of compliance with this requirement. The FAQs indicate the agencies anticipate beginning to collect attestations starting in 2022.

Provider Directory Requirements

The No Surprises Act imposes certain requirements regarding directories of in-network or participating providers. According to the FAQs, the agencies will eventually issue regulations implementing these requirements, but not before the effective date (i.e., the first day of the first plan year beginning on or after January 1, 2022). Nevertheless, the compliance date ***is not*** being delayed. Until regulations are issued, plans must comply with these requirements using a good faith, reasonable interpretation of the statute. Furthermore, the FAQs indicate the agencies will not deem a plan to be out of compliance with these requirements so long as the plan applies in-network cost-sharing requirements in a case when a covered individual receives items and services from an out-of-network provider and the individual was provided inaccurate information by the plan under a provider directory or response protocol that stated that the provider or facility was in-network.

Reporting on Prescription Drug Costs

As mentioned above, the No Surprises Act includes a requirement that group health plans report certain prescription drug cost information to the agencies. According to the Act, the first such report was due by December 27, 2021, with a second report due on June 1, 2022. The agencies intend to issue regulations implementing this requirement. Pending the issuance of such regulations, the reporting deadlines are being postponed, likely until ***December 27, 2022.*** According to the FAQs, plans should be prepared to report the required information with respect to 2020 and 2021 by that date.

Continuity of Care

Under the No Surprises Act, group health plans must implement protections to ensure continuity of care in instances when terminations of certain contractual relationships result in changes in provider or facility network status effective for the plan year beginning on or after January 1, 2022. The compliance date of this requirement ***is not*** being delayed. However, the agencies will not be issuing regulations implementing this provision prior to January 1, 2022. Until regulations are issued, plans are expected to comply with these requirements using a good faith, reasonable interpretation of the statute.

The Hays Research and Compliance team will continue to monitor the situation and provide important updates as they become available.

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www.hayscompanies.com | info@hayscompanies.com

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