IslerDare PC

Employee Benefits Update September 8, 2021

Delay in Enforcement of Key Requirements Under the No Surprises Act and the Group Health Plan Transparency Rules

Executive Summary

On August 20, 2021, the Departments of Labor, Health and Human Services, and Treasury (the "Departments") issued Frequently Asked Questions ("FAQs") delaying the implementation of certain enhanced disclosures and transparency requirements for group health plans under the No Surprises Act of the Consolidated Appropriations Act, 2021 ("CAA") and Transparency in Coverage Final Rules ("TiC Final Rules") (see our previous Employee Benefits Update). These requirements were generally scheduled to take effect either on December 27, 2021, or on or after January 1, 2022, but the Departments have delayed the effective dates after recognizing the considerable administrative burden they impose on group health plan administrators, and to allow time for additional guidance to be released. This update discusses the key modifications to the effective dates. Despite these extended compliance deadlines, plan sponsors will want to continue working with their TPAs and other vendors to ensure timely compliance with the requirements.

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- Transparency Tools Using Publicly Available Machine-Readable Files: Under the TiC Final Rules, non-grandfathered group health plans and issuers offering non-grandfathered health insurance coverage are required to provide transparency tools using machine-readable files that must be made available on a public website, with data regarding in-network provider allowable amounts, out-of-network allowed amounts, billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription. Compliance was originally required for plan years beginning on or after January 1, 2022, but the disclosure requirement for in-network provider allowable amounts, out-of-network allowed amounts, and billed charges for covered items and services has been delayed until July 1, 2022. The disclosure requirement for the negotiated rates and historical net prices for covered prescription drugs has been delayed to a later date pending further rulemaking and a review of the overlapping CAA reporting requirements (see Reporting on Drug Costs and Other Costs below).

Important Dates

September 15:

- File Form 8928 to report excise taxes for noncompliance with certain group health plan requirements
- File Form 5500 for calendar-year plans eligible for an automatic extension (without filing a Form 5558)
- Minimum funding deadline for pension plans

September 30:

- Distribute Summary Annual Report for calendar-year plans, if Form 5500 was filed on July 31

October 14:

- Distribute Notice of Medicare Part D creditable prescription drug coverage to health plan participants, unless previously provided in open enrollment materials

- Reporting on Drug Costs and Other Costs: Under the CAA, group health plans and issuers are required to report detailed prescription drug cost information to the Departments, including the 50 most dispensed brand drugs per plan, the 50 most expensive drugs per plan, and the data regarding 50 prescription drugs with the greatest increase in plan expenditures from the prior year, all broken out into specific categories. In addition, plans and issuers must report, among other things, total spending by the plan (broken down by hospital costs, provider costs, and primary care vs. specialty care); spending on prescription drugs; and premium information, including the impact on premiums of rebates, fees, and other renumeration paid by drug manufacturers or pharmacy benefit managers. The Departments have delayed enforcement of the first two reporting deadlines (*i.e.*, December 27, 2021 and June 1, 2022) until the issuance of further guidance; however, plans are strongly encouraged to prepare 2020 and 2021 plan year data for reporting no later than December 27, 2022.

- Price Comparison Information: Under the TiC Final Rules, group health plans and issuers are required to make price comparison information available to participants via an online self-service tool and in paper upon request. Under the CAA, plans are required to make similar information available via phone, but the CAA Rules have a different (and earlier) effective date. Because the TiC Final Rules and CAA rules are largely duplicative, the Departments have provided that all price comparison information disclosures will be required for plan years beginning on or after January 1, 2023.

- Insurance Identification Cards: Under the CAA, group health plans and issuers must include certain information on insurance cards, such as deductibles, out-of-pocket limits, and consumer assistance contact information. Pending future rulemaking, plans and issuers are now expected to implement the identification card requirements using a good faith, reasonable interpretation of the law, for plan years beginning on or after January 1, 2022.

- Advanced Explanation of Benefits/Good Faith Estimates: Under the CAA, group health plans are required to provide an Advanced Explanation of Benefits, at least three days in advance of a selected service or procedure, detailing whether the provider is in-network; good faith estimates of provider charges for the specific scheduled service and the cost sharing that would apply to the participant; and the amount already incurred toward any financial responsibility. Additionally, providers and facilities must, upon request, provide good faith estimates of anticipated charges. Enforcement of these requirements now will be deferred until regulations are issued.

- Prohibition on Gag Clauses: The CAA prohibits group health plans from entering into agreements with health providers or other service providers that would prevent them from making available specific price or quality information. Although this requirement took effect December 27, 2020, plans and issuers are expected to implement these requirements using good faith, reasonable compliance. Guidance regarding procedures for submitting attestations for compliance is forthcoming, and collection of those attestations is anticipated to begin in 2022.

- Continuity of Care: Group health plans must implement protections when the plan changes networks to ensure continuity of care. Enforcement of these rules will be deferred until additional regulations are issued; however, plans are expected to comply with these requirements using a good faith, reasonable interpretation of the CAA.

- Provider Directory Requirements: Group health plans are required to maintain a provider directory with up-to-date information about in-network or participating providers, which must be updated at least every 90 days. Enforcement is now delayed until regulations are issued, but plans must comply with these requirements using a good faith, reasonable interpretation of the CAA.

To discuss the key requirements under the No Surprises Act of the CAA, the Transparency in Coverage Final Rules, or other employee benefits matters, please contact any member of our Employee Benefits and Executive Compensation Group below.

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