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Benefits Alert

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Departments issue FAQs regarding implementation timing of group health plan reforms

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Relevant agencies, including the Departments of Labor, Treasury, and Health and Human Services, recently issued FAQs to explain when regulations might be issued and what plan sponsors and administrators should do in the interim.

What's the Impact

- The FAQs cover changes already in effect alongside changes effective in 2022 and 2023
- Drug pricing, EOBs, participant IDs, provider directories, and other items related to plan transparency are addressed by the FAQs
- Plan sponsors and administrators should work with experienced counsel to determine whether any plan/SPD modifications or administrative service agreement amendments are necessary

In December 2020, President Biden signed the Consolidated Appropriations Act, 2021 (the CAA) into law, which — among other things — contained several reforms applicable to group health plans. Some of the reforms were effective immediately or shortly after enactment; most were

scheduled to become effective on January 1, 2022; and a few were to become effective in later years. Relevant agencies (i.e., the Departments of Labor, Treasury, and Health and Human Services (the Departments)) were directed to issue implementing regulations to guide plan sponsors and administrators.

Given the complexity of the new group health plan reforms, and the need to accommodate existing laws and regulations, it would be impossible for the Departments to issue regulations covering all of the reforms before their statutory effective dates. Recognizing this, the Departments issued "FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49" to explain when regulations might be issued and what plan sponsors and administrators should do in the interim.

Here is a summary of the FAQs that require action from plan sponsors and administrators.

Change already in effect

"Gag clauses"

Effective December 27, 2020, plans with network-based designs cannot enter into agreements with a provider, association of providers, third-party administrator, or other service provider offering access to the network if such an agreement restricts the plan from (1) providing provider-specific cost or quality of care data to referring providers, covered individuals, or plan sponsors, (2) accessing de-identified claims and encounter data for each covered individual, and (3) sharing such information consistent with applicable privacy regulations. The Departments consider the CAA's prohibition on these "gag clauses" to be self-implementing, and therefore, no regulations will be issued.

Note that the CAA also requires plans and issuers to attest to the Departments on an annual basis that they are not subject to any gag clause of this type. Guidance about the attestation requirement will be issued in the future, and the Departments anticipate the collection of attestations to occur in 2022.

Changes effective for plan years beginning on or after January 1, 2022

Participant plan identification cards

The CAA includes provisions requiring group health plans to ensure that physical and electronic insurance identification (ID) cards include the (1) applicable deductibles, (2) out-of-pocket maximums, and (3) contact information for consumer assistance. Regulations will not be issued before the requirement becomes effective, but the Departments will enforce this requirement subject to a reasonable, good faith compliance standard. Specifically, the Departments will consider (1) the specific data elements on the ID card, (2) whether any information not on the card is available through information on the card (i.e., a website or phone number), and (3) the date on which the required information is included on the ID card. The Departments also suggested that applicable major medical deductible and out-of-pocket maximum information

and a website (or QR code) or phone number be included on the ID card to obtain the rest of the cost-sharing information.

Provider directories

The CAA requires group health plans to take steps to ensure that provider directors are routinely maintained and updated to reflect the network status of all providers in a directory. If covered individuals receive services from providers and the provider directory was inaccurate with respect to the providers' network status, covered individuals cannot be required to pay more in cost-sharing than they would have had to if they had received services from an in-network provider. The Departments will apply a reasonable, good faith compliance standard when enforcing the requirement. Also, the Departments will not deem plans or issuers to be non-compliant if procedures are in place to ensure that covered individuals are charged in-network cost-sharing amounts when they are provided inaccurate information.

Continuity of care

The CAA requires that group health plans adopt, effective January 1, 2022, continuity of care procedures to ensure that certain covered individuals are not harmed when a provider ceases to be a participating or in-network provider. More specifically, an individual receiving care from an in-network provider for a serious condition must continue to receive such care at in-network cost-sharing levels for up to 90 days of the provider ceasing to be a participating or in-network provider. The Departments will not issue regulations prior to the January 1, 2022 effective date. Instead, the Departments will apply a reasonable, good faith compliance standard when enforcing this requirement. Note that most third-party claims administrators already have continuity of care procedures in place, and in many cases, these are similar to what is required under the CAA.

Balance billing disclosures

The CAA requires plans and issuers to make disclosures regarding balance billing protections publicly available (e.g., on a website) and with certain Explanation of Benefits information. The Departments will not issue regulations before the January 1, 2022, effective date. Instead, the Departments will apply a reasonable, good faith compliance standard when enforcing this requirement. A model disclosure notice is available from the Department of Labor website.

Change effective July 1, 2022 (for plans years beginning on or after January 1, 2022)

Publishing machine-readable files of healthcare and prescription drug pricing information

Before the CAA, the Departments issued regulations requiring group health plans to take several steps to improve cost transparency for healthcare services. Among those requirements was the obligation to publish machine-readable files containing in-network rates and out-of-network allowed amounts and billed charges for healthcare services, including pricing information for

prescription drugs. This requirement was set to become effective on January 1, 2022. However, the CAA included provisions that substantially modified the cost transparency regulations.

Given the potential for duplicative and overlapping requirements between the cost transparency regulations and the CAA, the Departments have delayed enforcement of the machine-readable file requirement for healthcare services to July 1, 2022. Further, the Departments will delay enforcement of the requirement to publish machine-readable files containing prescription drug pricing information until future regulations are issued.

Change effective for plan years beginning on or after January 1, 2023

Price transparency tools

The Departments' previous cost transparency regulations also required group health plans to make price comparison information available to covered individuals through an internet-based self-service tool and, upon request, in paper form. This requirement would have been effective for a sub-set of healthcare services on January 1, 2023, and for all healthcare services on July 1, 2024.

The CAA also included a requirement that group health plans make price comparison information available through the plan's or issuer's website *and by telephone*. The CAA's requirement, however, was scheduled to become effective on January 1, 2022.

The Departments observed that the cost transparency regulations and the CAA's requirements are substantially similar. New regulations describing the comparison tool requirements under both the previous cost transparency regulations and the CAA will be issued in the future. In addition, because group health plans have been working toward implementation of the first phase (i.e., price comparison of a sub-set of healthcare services) on January 1, 2023, the Departments will not enforce the CAA's requirements until at least that date. Until then, the Departments will focus on assisting group health plans and issuers with compliance with the new requirements.

Other changes with delayed enforcement

Prescription drug benefit and drug cost reporting

The CAA mandates that group health plans report detailed information to the Departments regarding the cost of prescription drugs. For example, group health plans must report the 50 most-dispensed brand drugs, number of paid claims for each of the 50 most-dispensed brand drugs, 50 costliest drugs in terms of annual spend, and 50 drugs with the greatest increase in cost. In addition, information must be reported related to rebates and how those rebates are applied. The first report was scheduled to be submitted no later than December 27, 2021, and then on June 1 of each year thereafter. Because plan sponsors need additional time to modify contractual arrangements with prescription drug manufacturers and develop the reporting procedures and programs for this requirement, the Departments will not enforce the December

27, 2021, or June 1, 2022, reporting requirement. Instead, the Departments encourage plans to prepare in good faith to submit 2020 and 2021 data by December 27, 2022.

Advanced explanation of benefits

The CAA required group health plans to issue explanations of benefits in advance (Advanced EOB) when requested by a covered individual. The Advanced EOB must include information related to (1) network status of the relevant provider(s), (2) contracted rates for in-network services, (3) a good faith estimate from the provider(s), (4) a good faith estimate of the amount the plan will pay to the provider and an estimate of any cost-sharing that the covered individual will be responsible to pay, and (5) appropriate disclaimers related to medical management requirement. This requirement was to be effective January 1, 2022, but the reality is that the necessary technical infrastructure has not been developed adequately to ensure effective data transfer between healthcare providers and health plans. Until regulations are issued, the Departments will not enforce this requirement.

Without question, the complexity of the CAA's new group health plan reforms is daunting and will require voluminous regulations over the next few years. The Departments' FAQs explaining enforcement delays and good faith compliance standards are certainly helpful, given that many requirements are effective, at least from a statutory perspective, on January 1, 2022. Although this is welcome relief, plan sponsors and administrators should continue to monitor their service providers to ensure that appropriate steps are underway to comply. Furthermore, plan sponsors and administrators are encouraged to consult with legal compliance when evaluating good faith compliance pending regulations and determining whether any plan/SPD modifications or administrative service agreement amendments are necessary.

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