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BLOG

Enforcement Delays for Group Health Plan Compliance

AUGUST 26, 2021

On August 20, 2021, the United States Departments of Labor, Health and Human Services, and Treasury (the Departments) jointly released a series of frequently asked questions (the Guidance) detailing a modified enforcement schedule for some of the transparency and surprise billing provisions under the Affordable Care Act (ACA) and Consolidated Appropriations Act, 2021 (CAA). In doing so, the Departments acknowledged the administrative and logistical challenges for plans and issuers inherent in complying with these new disclosure obligations. The Departments also recognized, in several areas, that additional guidance or notice and comment rulemaking is necessary before compliance can be reasonably expected. Accordingly, the Departments delayed the compliance deadlines for some of the more onerous provisions under the CAA.[1] The chart below lists the relevant provisions, their original effective dates, and current effective dates under the Guidance.

Key Takeaways:

- In recently issued FAQs, the Departments have delayed several key compliance deadlines for group health plans under the CAA and the Transparency in Coverage Rule under the ACA, including: public pricing disclosures, advanced explanations of benefits, a price comparison tool to enable participants to compare cost-sharing amounts for specific network providers, and extensive drug cost reporting.
- The guidance does not delay other CAA group health plan requirements, such as surprise medical billing requirements that take effect January 1, 2022, or the requirement to conduct a NQTL comparative analysis under the Mental Health Parity Act, which is already in effect.

NO.	REQUIREMENT	ORIGINAL EFFECTIVE DATE	DELAYED EFFECTIVE DATE

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1	**Machine Readable Files.** Under the Transparency in Coverage Final Rules ("TiC Final Rules"), non-grandfathered group health plans and issuers offering non-grandfathered health insurance coverage in the group and individual markets are required to disclose, through machine-readable files (i.e., digital representations of data or information in files that can be imported or read by computers for further processing without human intervention), (1) in-network provider rates for covered items and services, (2) out-of-network allowed amounts and billed charges for covered items and services, and (3) negotiated rates and historical net prices for covered prescription drugs. This data must be posted on the plans' or issuers' public websites. *See a related discussion of pharmacy benefit reporting requirements under the CAA at number 10 below.*	Compliance under the TiC Final Rules was required for plan years beginning on or after January 1, 2022.	Enforcement of the disclosure requirement for prescription drug pricing under the TiC Final Rules is delayed to an undisclosed later date pending further notice and comment rulemaking, because of overlapping reporting requirements added by the CAA. Enforcement of disclosure requirements for in-network rates and out-of-network allowed amounts and billed charges is delayed until July 1, 2022.

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2	**Price Comparison Tools.** Plans and issuers are required, under the TiC Final Rules, to make price comparison information available to participants via an online self-service tool and in paper copy upon request. Under the CAA, plans and issuers are required to make similar information available to participants by phone.	Under the TiC Final Rules, compliance for 500 specified items and services was required for plan years beginning on or after January 1, 2023, and January 1, 2024 for all other items. The similar requirement under the CAA was effective for plan years beginning on or after January 1, 2022.	Recognizing that the price comparison requirements under the TiC Final Rules and CAA are "largely duplicative," except for the ability to receive such information via phone, enforcement under both laws is delayed until January 1, 2023. The Departments intend to propose rules requiring that the same TiC pricing information available via online self-service tool, in paper form, and also over the phone upon request.
3	**Insurance Identification Cards.** Under the CAA, plans and issuers are required to include on insurance ID cards information on any applicable deductible, out-of-pocket-maximum limitation, and telephone number and website through which participants can access consumer assistance information.	Plan years beginning on or after January 1, 2022.	Delayed indefinitely. The Departments anticipate releasing additional implementing guidance, but until that time good faith compliance is required.

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4	**Good Faith Estimate.** Under the CAA, when an individual schedules items or services, providers and facilities are required to provide a good faith estimate of anticipated charges. This estimate must also be provided upon request and include expected billing and diagnostic codes. The provider must also transmit this information to the individual's health plan.	Plan years beginning on or after January 1, 2022.	Delayed indefinitely. The Departments anticipate releasing additional implementing guidance, but until that time good faith compliance is required.
5	**Advanced Explanation of Benefits.** Plans and issuers are required, under the CAA, to provide participants who schedule procedures at least 3 business days in advance with an Advanced Explanation of Benefits ("EOB") detailing, among other things, whether the provider or facility is in-network, the good faith estimate received from the provider (described above), and an estimate of the participant's cost-sharing obligation.	Plan years beginning on or after January 1, 2022.	Delayed indefinitely. Given the complexities inherent in administering the good faith estimate requirement described directly above, enforcement is also delayed until after further guidance is released.
6	**Prohibition on Gag Clauses.** The CAA prohibits plans and issuers from entering into agreements with health providers (or a network of providers), third party administrators, or other service providers that would restrict those parties from disclosing specific price or quality information, which includes de-identified information, or certain claim information (consistent with HIPAA).	December 27, 2020	Delayed indefinitely. The Departments anticipate releasing additional implementing guidance, but until that time good faith compliance is required.

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7	**Provider Directories.** Plans and issuers are required to maintain an up-to-date and accurate provider directory and establish a protocol to respond to participants' requests about a provider's in-network status. Under the CAA, if a participant is supplied incorrect information via the database or response protocol, they may not be held responsible for a cost-sharing amount that is greater than the cost-sharing amount that would have been imposed for the same items and services furnished by an in-network provider or apply out-of-network out-of-pocket maximums.	Plan years beginning on or after January 1, 2022.	Delayed indefinitely. The Departments anticipate releasing additional implementing guidance, but until that time good faith compliance is required.
8	**Balance Billing Disclosures.** The CAA also mandates that plans and issuers inform participants via public websites and on each EOB that balance billing for certain emergency services is prohibited.	Plan years beginning on or after January 1, 2022.	Delayed indefinitely. The Departments issued guidance in July 2021 and anticipate releasing additional implementing guidance, but until that time good faith compliance is required.
9	**Continuity of Care.** The CAA protects participants undergoing treatment for serious or complex conditions, institutional or inpatient care, pregnancy-related treatment, or having scheduled non-elective treatment or terminally ill participants from immediately losing coverage upon a change in a provider or facilities' in-network status. The CAA imposes a notice requirement of changes to a provider or facility's in-network status and in some cases, the participant must be provided up to 90 days of continued coverage at the in-network rate.	Plan years beginning on or after January 1, 2022.	Delayed indefinitely. The Departments anticipate releasing additional implementing guidance, but until that time good faith compliance is required.

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10	**Pharmacy Benefits and Drug Costs Reporting.** Under the CAA, plans and issuers are required to submit to the Departments a broad array of information on prescription drug benefits and drug costs. Required information includes a list of the 50 most frequently dispensed prescription drugs paid under the plan, 50 most costly prescription drugs covered by the plan, and 50 prescription drugs with the greatest increase in plan expenditures over the preceding plan year subject to report. Additionally, plans and issuers must also report to the Departments total spending and costs for various services and items and total premiums broken down by participant and employer payments, among other data.	The CAA includes two reporting deadlines of December 27, 2021 and June 1, 2022 (with regular reporting by June 1 of each subsequent year).	Delayed indefinitely. Recognizing the "significant operational challenges" in complying with these reporting requirements, disclosure is delayed until further guidance is issued. However, plans and issuers are "strongly encouraged" to prepare for compliance by December 27, 2022 for 2020 and 2021 data.

[1] Note that with respect to fully-insured group health plans and issuers for which the states are the primary enforcers, the Departments consistently encourage a "similar enforcement approach" with respect to the modified deadlines adopted under the Guidance.

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Authors

Amy Gordon

Joanna Kerpen

Susan Nash

Jamie Weyeneth

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Amy Gordon

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