Arizona Association of Health Underwriters

Announcemnt from NAHU:

DOL Grants NAHU Requests for Transparency in Coverage and CAA Delays

Late on Friday the Department of Labor (DOL) released FAQs regarding the upcoming implementation of the Transparency in Coverage (TiC) final rule and sections of the Consolidated Appropriations Act (CAA). The FAQs provide an update in the timeline for when these policies will go in to place. NAHU has had ongoing concerns regarding the initial timing for enforcement of TiC and the CAA and we have shared our thoughts in our comments for the TiC rules and in several letters on separate provisions of the CAA. As the FAQ addresses, many of the timelines in TiC and the CAA don't align with each other even though the data or processes for compliance overlap. There are also many concerns about the technology needed for compliance for many of these provisions which will need to be in place prior to health plans and fiduciaries being able to implement the policies.
NAHU specifically requested delays for the TiC Machine-Readable Files, Reporting on Pharmacy Benefits and Drug Costs and the Advanced Explanation of Benefits, among others. We support the intent behind the provisions, but commented to the Departments that more time would be needed in order to implement the provisions in an effective manner. NAHU is pleased that the Departments have delayed these measures and we plan to comment on future rulemaking for these issues.

The following sections of these laws were addressed in the FAQs along with new dates for implementation. NAHU will provide additional information on these FAQs in this week's Washington Update and Healthcare Happy Hour podcast, as well as our next Compliance Corner webinar on September 9 at 1:00 p.m. ET.

TiC Machine-Readable Files

TiC requires non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to disclose on a public website information 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 in three separate machine-readable files.

Previous implementation date: plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Updated enforcement: July 1, 2022 to disclose in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services. The date to disclose prices for prescription drugs is delayed until further rulemaking is issued.

Reporting on Pharmacy Benefits and Drug Costs

The CAA includes certain reporting requirements for plans and issuers. These reporting requirements primarily relate to prescription drug expenditures, requiring that plans and issuers submit relevant information to the Departments. This information includes general information regarding the plan or coverage, such as the beginning and end dates of the plan year, the number of participants, beneficiaries, or enrollees, as applicable, and each state in which the plan or coverage is offered. Plans and issuers must also report the 50 most frequently dispensed brand prescription drugs, and the total number of paid claims for each such drug; the 50 most costly prescription drugs by total annual spending, and the annual amount spent by the plan or coverage for each such drug; and the 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year.

Previous implementation date: specified information by the first deadline for reporting on December 27, 2021 or the second deadline for reporting on June 1, 2022 depending on plan year.

Updated enforcement: The Departments intend to issue regulations that will address the pharmacy benefit and drug cost reporting requirements. Until regulations or further guidance is issued, the Departments strongly encourage plans and issuers to start working to ensure that they are in a position to be able to begin reporting the required information with respect to 2020 and 2021 data by December 27, 2022.

Price Comparison Tools

TiC requires plans and issuers to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request.

Previous implementation date: plan years (in the individual market, policy years) beginning on or after January 1, 2023, for the 500 items and services listed by the DOL.All covered items and services, for plan or policy years beginning on or after January 1, 2024.

Updated enforcement: Departments will defer enforcement of the requirement that a plan or issuer make available a price comparison tool (by internet website, in paper form, or telephone) before plan years (in the individual market, policy years) beginning on or after January 1, 2023. The Departments encourage plans and issuers with existing tools or programs to continue to make those tools or programs accessible. Plans and issuers are encouraged to work toward updating the standards of these tools and programs to meet the minimum requirements in the TiC Final Rules by the regulatory applicability date.

Transparency in Plan or Insurance Identification Cards

Plans and issuers are required to include in clear writing, on any physical or electronic plan or insurance identification (ID) card issued to participants, beneficiaries, or enrollees, any applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance.

Previous implementation date: plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Updated enforcement: The Departments will provide future rulemaking addressing implementation of the ID card requirements, including how plans and issuers offering complex plan and coverage designs should represent information on an ID card. Until that time, plans and issuers are expected to implement the ID card requirements using a good faith, reasonable interpretation of the law.

Good Faith Estimate

The CAA requires providers and facilities, upon an individual's scheduling of items or services, or upon request, to inquire if the individual is enrolled in a health plan or health insurance coverage, and to provide a notification of the good faith estimate of the expected charges for furnishing the scheduled item or service and any items or services reasonably expected to be provided in conjunction with those items and services, including those provided by another provider or facility, with the expected billing and diagnostic codes for these items and services.

If the individual is enrolled in a health plan or coverage (and is seeking to have a claim for the item or service submitted to the plan or coverage), the provider must provide this notification to the individual's plan or coverage.

In the case that the individual is not enrolled in a health plan or coverage or does not seek to have a claim for the item or service submitted to the plan or coverage, the provider must provide this notification to the individual.

Previous implementation date: plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Updated enforcement: HHS intends to issue regulations implementing good faith estimate requirements for individuals not enrolled in a health plan or coverage or who are not seeking to have a claim for the scheduled items or services submitted to the plan or coverage prior to the statutory effective date. Until rulemaking to fully implement this requirement to provide such a good faith estimate to an individual's plan or coverage under is adopted and applicable, HHS will defer enforcement of the requirement that providers and facilities provide good faith estimate information for individuals enrolled in a health plan or coverage and seeking to submit a claim for scheduled items or services to their plan or coverage.

Advanced Explanation of Benefits

The CAA requires plans and issuers, upon receiving a "good faith estimate" regarding an item or service to send a participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) an Advanced Explanation of Benefits notification in clear and understandable language. The notification must include: (1) the network status of the provider or facility; (2) the contracted rate for the item or service, or if the provider or facility is not a participating provider or facility, a description of how the individual can obtain information on providers and facilities that are participating; (3) the good faith estimate received from the provider; (4) a good faith estimate of the amount the plan or coverage is responsible for paying, and the amount of any cost-sharing for which the individual would be responsible for paying with respect to the good faith estimate received from the provider; and (5) disclaimers indicating whether coverage is subject to any medical management techniques.

Previous implementation date: plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Updated enforcement: The Departments will undertake future comment and rulemaking. Until that time, the Departments will defer enforcement of the requirement that plans and issuers must provide an Advanced Explanation of Benefits.

Prohibition on Gag Clauses on Price and Quality Data

The CAA prohibits plans and issuers from entering into an agreement 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 or issuer from: (1) providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage; (2) electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee; and (3) sharing such information, consistent with applicable privacy regulations. In addition, plans and issuers must annually submit to the Departments an attestation of compliance with these requirements.

Previous implementation date: effective December 27, 2020 (the date of enactment of the CAA).

Updated enforcement: The CAA is self-implementing, and the Departments do not expect to issue regulations on gag clauses at this time. Until any further guidance is issued, plans and issuers are expected to implement the requirements prohibiting gag clauses using a good faith, reasonable interpretation of the statute. However, the Departments intend to issue implementation guidance to explain how plans and issuers should submit their attestations of compliance and anticipate beginning to collect attestations starting in 2022.

Protecting Patients and Improving the Accuracy of Provider Directory Information

The CAA establishes standards related to provider directories that are intended to protect participants, beneficiaries, and enrollees with benefits under a plan or coverage from surprise billing. These provisions generally require plans and issuers to establish a process to update and verify the accuracy of provider directory information and to establish a protocol for responding to requests by telephone and electronic communication from a participant, beneficiary, or enrollee about a provider's network participation status.

The CAA also requires plans and issuers to make certain disclosures regarding balance billing protections to participants, beneficiaries, and enrollees that are similar to disclosure requirements applicable to providers and facilities.

Previous implementation date: plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Updated enforcement: The Departments intend to undertake notice and comment rulemaking to implement the provider directory requirements, but rulemaking will not be issued until after January 1, 2022.

The Departments will address the balance billing requirements in more detail in future guidance or notice and comment rulemaking. The Departments have already issued Requirements Related to Surprise Billing; Part 1 (July 2021 Interim Final Rules), and will continue to undertake rulemaking to implement the CAA balance billing requirements.

Continuity of Care

The CAA establishes continuity of care protections that apply in the case of an individual with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer. These protections ensure continuity of care in instances when terminations of certain contractual relationships result in changes in provider or facility network status.

Previous implementation date: plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Updated enforcement: The Departments intend to undertake notice and comment rulemaking to implement the continuity of care requirements, but do not expect to do so until after January 1, 2022. Until rulemaking to fully implement these provisions is adopted and applicable, plans, issuers, providers, and facilities are expected to implement the requirements using a good faith, reasonable interpretation of the statute.