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Employee Benefit Plan Review

Group Health Plan Sponsors Are Getting Serious About Pricing Transparency and Avoiding Surprise Billing – Are You Keeping Up with the Latest Guidance and Phased Enforcement Deadlines?

By Amber N. Roberts, Beth Alcalde, Elizabeth F. Hodge, Bruce D. Platt, And Thomas A. Range

Over the summer, the Department of Health and Human Services ("HHS"), the Department of Labor ("Labor"), and the Department of the Treasury ("Treasury") (collectively, "the Departments") along with the Office of Personnel Management ("OPM") released an interim final rule[1] related to the No Surprises Act, legislation designed to protect patients from unexpected medical bills. The Departments followed that by issuing guidance in late August 2021 in the form of FAQs ("FAQs"). As noted below, in certain instances, the implementation dates or enforcement deadlines were delayed, though in at least some of these deferrals, good faith, reasonable interpretations by health plan sponsors and insurers are still required.

Health Cost Transparency Obligations

The Departments' interim final rule, and the latest interpretative guidance, arrives in the broader context of a number of new health cost transparency obligations imposed upon plan sponsors (the employers or organizations that offer group health plans to employees) rolling out over the coming months and years. While many of the pricing transparency measures can be implemented by third parties, plan fiduciaries must ultimately ensure compliance.

Compliance Deadlines

Compliance deadlines had been rapidly approaching under the interim final rule, but the FAQs defer the enforcement of numerous transparency and surprise billing requirements. Unlike some true deferrals of regulatory changes, however, the Departments were clear that the primary reason for the partial delay was to coordinate with duplicative and/or complimentary regulations promulgated by other agencies in similar areas. As such, good faith compliance is often still required. As either true compliance deadlines or softer (non-enforced) good faith interpretive compliance deadlines for the new pricing transparency requirements or the new prohibitions on surprise billing that apply to group health plans draw near, plan sponsors will need to use the second half of 2021 and much of 2022 to prepare. This article is intended to walk through the original interim

final rule requirements. While the FAQs' delays will be flagged, this article is not focused on a detailed discussion of the various deferrals in enforcement.

Transparency in Coverage Rule

To understand the shift toward openness and transparency in pricing for group health plan participants, let's first focus on the Transparency in Coverage Rule[2] issued by the Departments in late 2020. Under the rule, group health plans (and health insurance issuers in the individual and group markets) must (1) upon request, disclose cost-sharing information to participants, beneficiaries and enrollees, and (2) disclose in-network provider negotiated rates, historical out-of-network allowed amounts, and prescription drug pricing information to the public via machine-readable files posted to a website. The Transparency in Coverage Rule originally took effect in January 2022.

Separately, plan sponsors must also contend with the employee benefit health and welfare plan provisions of the Consolidated Appropriations Act of 2021[3] ("CAA"). The CAA, which includes the No Surprises Act, contains a myriad of transparency and disclosure requirements that originally took effect in 2021 and 2022. Plan sponsors will need to work closely with service providers and issuers to ensure that group health plans are well-positioned to comply. Below we provide a high-level summary of the new rules.

The regulations issued by the Departments create a federal standard designed to provide consumers with health pricing information necessary to make informed decisions. The Transparency in Coverage Rule is designed to complement the hospital pricing transparency rule that took effect earlier this year, although many hospitals appear to be deficient in complying with it.

- *Machine Readable Public Pricing Disclosures*. Most non-grandfathered group health plans and health insurance issuers offering non-grandfathered health insurance coverage must disclose pricing information to the public through three machine-readable files. One file will disclose payment rates negotiated between plans or issuers and providers for all covered items and services. The second file will disclose the unique amounts a plan or issuer allowed, as well as associated billed charges, for covered items or services furnished by out-of-network providers during a specified time period. A third file must include prescription drug pricing information. The Departments will exercise enforcement discretion and defer enforcement of the requirement to publish a machine-readable file related to prescription drugs while it engages in notice-and-comment rulemaking to consider whether the prescription drug machine-readable file requirement is still appropriate. Also, with respect to plan years beginning on or after January 1, 2022, the Departments will exercise enforcement discretion and defer enforcement of the requirement to make public the machine-readable files for in-network rates and out-of-network allowed amounts and billed charges until July 1, 2022.
- *Cost-Sharing Information Self-Service Tool*. Most non-grandfathered group health plans and health insurance issuers offering non-grandfathered health insurance coverage must disclose, upon request, cost estimates (in the form of seven content specific elements) for covered items and services. Disclosures must be made through a self-service tool made available by the plan or issuer on an internet website (and in paper form upon request). Plans and issuers are required to provide estimates for an initial list of 500 items and services beginning January 1, 2023 – however, estimates for *all* items and services described in the Rule must be available by January 1, 2024. The FAQs acknowledge that many of the internet price-comparison tool requirements are duplicative of separate transparency in coverage rules. The focus is therefore first going to be on the insurers' own website resources, before moving to the self-service internet tool.

Pricing Transparency in the CAA

The CAA, one of the longest bills ever passed by Congress, contains a number of pricing transparency provisions that apply to providers and group health plans.

- *No "Gag" Clauses*. Effective December 27, 2020, group health plans and health insurers may not enter 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. The FAQs confirm that no regulations on this point are forthcoming, and so plan sponsors are left to use their reasonable, good faith interpretations of the statute.
- *Mental Health Parity Disclosures*. Effective February 10, 2021, group health plans must perform and document comparative analyses of compliance with the Mental Health Parity and Addiction Equity Act.
- *New 408(b)(2) Disclosures*. Covered service providers must disclose their direct and indirect compensation above $1,000 received during the term of a contract or arrangement to a responsible plan fiduciary of a covered health plan. Annual

disclosure requirements are effective December 27, 2021.

- *Mandatory Drug Price Reporting*. Group health plans must provide the Departments with certain information regarding costs associated with the plan's prescription drug benefit, effective December 27, 2021. Subsequent annual disclosures will be due by June 1 of each year.

No Surprises Act

For group health plans and health insurance issuers, except as noted below, the provisions will take effect for plan, policy, or contract years beginning on or after January 1, 2022.

Major provisions in the No Surprises Act under the CAA include a ban on:

(1) Surprise billing for emergency services;
(2) High out-of-network cost-sharing for emergency and non-emergency services;
(3) Out-of-network charges for ancillary care at an in-network facility in all circumstances; and
(4) Other out-of-network charges without advance notice.

The No Surprises Act also:

(1) Requires plans to provide patients with an advanced explanation of benefits before scheduled care (upon request). Based on stakeholder comments, the Departments will engage in future notice and comment rulemaking address complex implementation issues, including appropriate data transfer standards, and will defer enforcement of this requirement. However, HHS will assess whether interim solutions might be feasible for insured consumers;
(2) Establishes plan ID card criteria. The Departments expect to engage in future rulemaking on this topic, but until then plans should implement the ID card requirements using a good faith, reasonable interpretation of the law. The FAQs also offer guidance on factors the Departments will consider when determining whether a plan complies with the ID card criteria;
(3) Establishes plan continuity of care requirements for certain patients. Pending rulemaking by the Departments, which is not expected before January 1, 2022, plans are expected to implement this requirement using a good faith, reasonable interpretation of the law; and
(4) Creates a negotiation and arbitration framework for settling pricing disputes between insurers and providers.

Under the No Surprises Act, plans:

(1) Will be required to have a verifiable provider directory. The Departments plan to engage in future rulemaking, but not before January 1, 2022, so plans are expected to implement the requirements of this provision using a good faith, reasonable interpretation of the statute. The FAQs describe the circumstances under which the Departments will not deem a plan to be out of compliance with the provider directory requirements; and
(2) Must also maintain a pricing comparison tool (available online and on the phone) to allow patients to compare expected out-of-pocket costs for items and services across multiple providers.

The Departments will defer enforcement of the requirement that a plan make available a price comparison tool before plan years beginning on or after January 1, 2023. Also, the Departments plan to engage in rulemaking and seek public comment as to whether the self-service tool requirement in the Transparency in Coverage Final Rule also satisfies the No Surprises Act requirements. In the meantime, plans with existing tools are encouraged to continue to make those tools accessible.

Conclusion

The Departments will continue to release additional guidance to ensure that insurers, providers, and plans are prepared to comply with the new health plan transparency standards. Plan sponsors will need to review various agreements, plan documents and draft disclosures well in advance of effective compliance deadlines. Compliance may also come at a cost – plan sponsors should be prepared for a potential short-term increase in administrative costs associated with implementation. Finally, it is also important to keep up with new guidance as the information becomes available in the coming months.

As noted above, though some of the technical enforcement dates or stated effective dates may have been delayed by the recent FAQs, the administrative and legal tools ultimately to be needed for compliance require "heavy lifting" on the part of plan sponsors to ensure they are compliant at the appropriate time.

Notes

1. *https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf.*
2. *https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage.*
3. *https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf.*

Amber N. Roberts (*amber.roberts@akerman.com*) is a Tax associate at Akerman LLP. Beth Alcalde (*beth.alcalde@akerman.com*) is a Tax and Employee Benefits and Executive Compensation partner at the firm. Elizabeth F. Hodge (*elizabeth.hodge@akerman.com*) and Thomas A. Range (*tom.range@akerman.com*) are Healthcare partners at the firm. Bruce D. Platt (*bruce.platt@akerman.com*) is the office managing partner in the firm's Tallahassee office.