Health and Welfare Plan Outlook and Implications for 2022

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Agenda

- Surprise Billing Updates
- Consolidated Appropriations Act (CAA) Health Plan Requirements and Enforcement Delays
- Affordable Care Act (ACA) Transparency in Coverage Final Rule Enforcement Delays
- Mental Health Parity Non-Quantitative Treatment Limitations (NQTL) Comparative Analysis and Department of Labor (DOL) Audits – Not Delayed!
- Cafeteria Plan Amendments
- Pandemic Outbreak Period Deadline Delays
- COVID-19 Vaccine Issues
- Cybersecurity

Surprise Billing

- No Surprises Act is generally effective for plan years beginning on or after January 1, 2022
- In-network (IN) cost-sharing applies to Out-of-Network (OON) services in the following instances:
  - Emergency services at hospital Emergency Department (ED)/freestanding ED
  - “Ancillary services” provided by OON provider at an IN facility
  - Non-emergency services performed by OON provider at IN facility
    - Exception applies if provider provides notice and individual consents to using OON provider
    - Exception not applicable to “ancillary services” or services arising from unforeseen, urgent medical needs
- Participant cost-sharing as if IN
- IN coinsurance is based on “recognized amount” (state law, “qualifying payment amount,” or amount approved by state with applicable All Payer Model Agreement)
- Providers may not balance bill the amount in excess of IN cost-sharing for the specified services

Surprise Billing

- Plan must make initial payment or initial denial within 30 days of clean claim
- Independent Dispute Resolution (IDR) process applies to disputes between providers and plan
  - 30-day cooling off period after initial payment/denial received to negotiate
  - If no agreement reached, either party may submit to IDR process
  - “Baseball style” arbitration (each side submits a payment offer and the arbitrator chooses)
    - IDR may not consider Usual & Customary, billed charges, governmental rate (e.g., Medicare)
- Similar rules apply to air ambulance services (but not ground ambulance)

Surprise Billing – Plan Sponsor Action Items

- Update plan documents, SPDs, and SBCs for new NSA requirements
  - Participant cost-sharing
  - Update definitions, i.e., Emergency, Recognized Amount, Qualifying Payment Amount
- Update Administrative Services Agreements for new NSA and IDR provisions (still waiting on IDR regulations)
- Group health plans must give individuals a notice about their rights under the No Surprises Act; model notice is good-faith compliance
- The notice must be posted on the plan's website and be included on each explanation of benefits for an item or service covered by the NSA
- The plan model notice is available on the DOL website: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act

CAA Requirements

Good-Faith Estimate

- When an individual schedules items or services, providers and facilities are required to provide a good-faith estimate of anticipated charges, upon request, and include expected billing and diagnostic codes. The provider must also transmit this information to the individual's health plan.

- Originally effective plan years beginning on or after January 1, 2022.

- Delayed indefinitely. Recognizing the logistical and technical challenges in transmitting required information between providers and plans/issuers, enforcement is delayed until further guidance is released.

CAA Requirements

Advanced EOB

- The advanced EOB requirement is triggered when a provider or facility notifies the insurer or plan that an enrollee is scheduled to receive a health care service and provides the good-faith estimate. In turn, plans and insurers must send the enrollee an advanced EOB, including whether the provider is in-network (or not); the contracted rate; provider's good-faith estimates of costs, cost-sharing, and progress towards meeting the patient's out-of-pocket maximum and deductible; any medical management techniques that apply; and make certain disclaimers.

- Originally effective 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.

CAA Requirements

Insurance ID Card

- 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.

- Originally effective plan years beginning on or after January 1, 2022.

- Delayed indefinitely. The Departments anticipate releasing additional implementing guidance.
- Until that time, good-faith compliance is required.

CAA Requirements

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.

- Originally effective plan years beginning on or after January 1, 2022.

- Delayed indefinitely. The Departments anticipate releasing additional implementing guidance.
- Until that time, good-faith compliance is required.

CAA Requirements

Prohibition on Gag Clauses

- Plans and issuers prohibited 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 and certain claim information (consistent with HIPAA).

- Originally effective December 27, 2020.

- Delayed indefinitely. The Departments anticipate releasing additional implementing guidance.
- Until that time, good-faith compliance is required.

CAA Requirements

Balance Billing Disclosures

- Plans and issuers required to inform participants via public websites and on each EOB that balance billing for certain emergency services is prohibited.

- Originally effective plan years beginning on or after January 1, 2022.

- Delayed indefinitely. The Departments issued Part I guidance in July 2021 and anticipate releasing additional implementing guidance.
- Until that time, good-faith compliance is required and can be met by issuing model disclosure notice.

CAA Requirements

Continuity of Care

- The CAA imposes a notice requirement of changes to a provider's or facility's in-network status, and in some cases, certain participants must be provided up to 90 days of continued coverage at the in-network rate. Protected conditions include: treatment for serious or complex conditions, institutional or inpatient care, pregnancy-related treatment, non-elective treatment, and terminally ill participants.

- Originally effective plan years beginning on or after January 1, 2022.

- Delayed indefinitely. The Departments anticipate releasing additional implementing guidance.
- Until that time, good-faith compliance is required.

CAA Requirements

Prescription Drug Reporting

- Plans and issuers required to submit prescription drug information including: 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.

- Originally effective December 27, 2021 (initial) and June 1, 2022 thereafter (with regular reporting by June 1 of each subsequent year).

- Delayed indefinitely. Recognizing the "significant operational challenges" in complying, 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.

ACA Transparency in Coverage

Machine-Readable Files

- Plans and issuers required to disclose, through machine-readable files: (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.

- Originally effective for plan years beginning on or after January 1, 2022.

- In-network rates and out-of-network allowed amounts and billed charges delayed until July 1, 2022.
- Prescription drug pricing delayed to an undisclosed later date pending further notice and comment rulemaking due to overlapping reporting requirements added by the CAA.

ACA Transparency in Coverage

Self-service Price Comparison Tool

- Plans and issuers are required 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.

- Compliance for 500 specified items and services was initially 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 the price comparison requirements under the TiC Final Rules and CAA are “largely duplicative.”
- Enforcement under both laws is delayed until January 1, 2023.

Broker/Consultant Compensation Disclosure

- Effective December 27, 2021 – Not delayed
- “Brokers” and “Consultants” to group health plans must disclose direct and indirect compensation (from any source) for certain services
  - Needed in order to meet the exception to ERISA Prohibited Transaction Rules
  - Appears to apply to all group health plans, including excepted benefits
  - Applies if compensation is over $1,000
  - Prior to entering into the contract; within 60 days of any change

New Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Requirements

- New obligations applicable to group health plans and health insurers in the individual and group markets that provide medical, surgical, and mental health (MH) and/or substance use disorder (SUD) benefits and that impose non-quantitative treatment limitations (NQTLs) on MH and/or SUD benefits
  - Group health plans must prepare and document NQTL comparative analysis
  - Effective 45 days after the date of enactment – February 10, 2021
  - New mandatory audits and DOL enforcement litigation
    - DOL currently auditing issuers and plans
    - FAQs About Mental Health and Substance Abuse Disorder Parity Implementation and the CAA, 2021, Part 45: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf

DOL NQTL Audits

- Top areas of focus include: prior authorization, concurrent review, in-network reimbursement rates, provider admission standards, and out-of-network reimbursement methodology
- Also focusing on coverage and limitations for methadone, maintenance care/therapy as it relates to methadone, and other types of medication-assisted treatment for SUD
- Be prepared to “show your work” – conclusory statements not acceptable
- It takes a village to complete

Plan Sponsor Concerns

- **TPA/PBM/Point Solution Agreements**
  - Agreements will need to be amended to cover additional ACA and CAA requirements and allocation of responsibility and liability
  - Indemnification provisions will be important – plan sponsor ultimately remains liable under self-insured plans
  - Agreements should address data privacy and security
- **ERISA Fiduciary Concerns**
  - Selection of Vendors
  - Monitoring of Vendors
  - Reasonableness of Fees/Pricing
  - Participant Disclosure Requirements
  - Authorized Representative/Provider Assignment of Benefit Issues
- **Liability/Enforcement**
  - Same enforcement mechanism as ACA – 4980D penalties
  - ERISA concerns:
    - Benefit Claims
    - Disclosure Requirements
    - Fiduciary Breach Liability
    - DOL Audits/Litigation

Consequences of Not Complying

- Internal Revenue Code Section 4980D
  - Enforcement by IRS/Treasury
  - $100/day excise tax
- ERISA
  - Enforcement by DOL through audits and litigation – penalties and specific performance
  - Suits by participants
- Public Health Service Act (PHSA) (non-federal governmental plans)
  - Enforcement by HHS

Cafeteria Plan Amendments

- Grace periods and carryovers
- Special rule regarding post-termination reimbursements from Health Flexible Spending Accounts (FSAs) during plan years 2020 and 2021
- Provides a special claims period and carryover rule for Dependent Care FSAs when a dependent “ages out” during the COVID-19 public health emergency
- Mid-year election changes for plan years ending in 2021
- Increase in Dependent Care FSA 2021 limit to $10,500

Plan Amendments – Notice 2021-15

- Plan amendments to adopt the Notice 2021-15 relief must be made by the end of the plan year following the plan year to which the amendment relates and can be retroactive
- The plan must be operated in accordance with the amended provisions retroactive to the effective date
- Participant notification requirements under ERISA apply

COVID-19 National Emergency Deadline Delays

- In May 2020, the DOL and the Internal Revenue Service (IRS) released a final rule temporarily tolling the period during which eligible employees can elect COBRA coverage, and the deadline for them to begin making COBRA premium payments, ERISA claims, and appeals and special enrollment – Outbreak Period
- This period began on March 1, 2020 and will run until the earlier of (i) one year from the triggering event, or (ii) 60 days after the end of the publicly declared COVID-19 national emergency, or another date if provided by the agencies in future guidance
- This rule is still ongoing

COVID-19 COBRA Deadline Delays

Event	Prior to National Emergency	Due to National Emergency
COBRA election period	60 days to elect continuation of coverage after the later of the qualifying event, or receiving a COBRA election notice	60-day time frame ignored during the outbreak period
COBRA premium payment	• Enrollees have 45 days from their COBRA election to make the first premium payment • Subsequent monthly payments must be made within a 30-day grace period that starts at the beginning of each coverage month	• Initial enrollment 45-day deadline ignored during the outbreak period • 30-day deadline ignored during the outbreak period
Election Notice	14-day deadline for plan administrators to furnish COBRA election notices	Permitted, but in practice No Change

COVID-19 Vaccine Update

- Biden “Path Out of the Pandemic Plan” requires mandatory vaccination or weekly testing for large employers (100 or more employees), federal workers and contractors, and health care industry workers
- Guidance imminent
- Employers have also been implementing a variety of carrot stick approaches through benefit plan design, such as insurance premium surcharges for unvaccinated, wellness program incentives for vaccinated, prizes, raffles, additional PTO days, and cash

Premium Surcharges for Unvaccinated

HIPAA Issues	HIPAA/ACA wellness program rules must be satisfied; is this a health contingent or participatory program? If health contingent (activity or outcomes based), must satisfy 30% test, reasonable alternative standard, etc.
ACA Affordability	Wellness program surcharges (other than tobacco) may impact ACA affordability because ALL participants are treated as failing to achieve the standard. ACA affordability threshold lower in 2022 and easier for individuals to qualify for premium subsidies on the exchange.
ADA/GINA Issues	Reasonable accommodation Spousal surcharges
Privacy Concerns	HIPAA, ADA, GINA

Cybersecurity

- On April 14, 2021, the DOL published guidance for plan fiduciaries, record-keepers, and plan participants on best practices for maintaining cybersecurity
- Questions related to cybersecurity protocols are now being incorporated into DOL audits; see
  - Tips for Hiring a Service Provider, https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/tips-for-hiring-a-service-provider-with-strong-security-practices.pdf
  - Cybersecurity Program Best Practices, https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/best-practices.pdf
  - Online Security Tips, https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/online-security-tips.pdf

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Susan Nash is a partner in the Chicago office of Winston & Strawn, LLP specializing in the area of health care reform and health and welfare benefits. She has extensive experience advising clients on innovative employee health benefit strategies and funding, including employer direct contracting with providers, population health management, on-site clinics, direct primary care, telehealth, private health care exchanges, VEBAs, and association health plans. She has counseled a wide variety of employers and health plans on HIPAA's privacy, security, and nondiscrimination requirements. Susan has also represented clients in negotiations and audits with the Internal Revenue Service and the Department of Labor. She regularly negotiates administrative services agreements, pharmacy benefit management agreements, and agreements with point solution vendors for health and welfare plans. Susan is recognized by Chambers USA, Best Lawyers in America, Employee Benefits, and the Legal 500 U.S. as a leading employee benefits attorney. She is also a Fellow of the American College of Employee Benefits Counsel.

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