TRUCKER ✦ HUSS

An Overview of the Group Health Plan Provisions of the Consolidated Appropriations Act and the Final Transparency in Coverage Regulations

MARY E. POWELL AND SARAH KANTER

JANUARY 2021

The Consolidated Appropriations Act, 2021 (the CAA) contains numerous provisions that impact group health plans. At a high level, these CAA provisions can be broken into three main categories: (1) reducing Out-of-Network (OON) costs for enrollees, (2) providing transparency regarding costs, and (3) permissive changes that allow participants enhanced access to amounts salary reduced to a Health Care Flexible Spending Account (HCFSA) and a Dependent Care Flexible Spending Account (DCFSA). This article will provide an overview of the first two categories. For information regarding the CAA's provisions related to HCFSAs and DCFSAs please see our January 6 Special Alert. In addition, in keeping with the theme of transparency, near the end of 2020 the Departments of Labor, Treasury, and Health and Human Services (HHS) issued the final "Transparency in Coverage" regulations, which include their own set of new disclosure requirements for group health plans — and this article will also provide an overview of these new rules.

Many of the provisions in the CAA are effective in 2022 (although some are effective in 2021). It is critical that plan sponsors have a basic understanding of these CAA provisions (as well as the Transparency in Coverage regulations) because they will necessitate amending vendor contracts and are likely to increase plan expenses in the next several years. We have included certain "action items" for plan sponsors throughout this article, to highlight the steps we recommend that plan sponsors take now to ensure plans will be compliant with these new requirements when they do go into effect.

The No Surprises Act

The *No Surprises Act* is intended to protect consumers from certain surprise medical bills, and it sets up an independent dispute resolution process between the plan and the out-of-network (OON) provider to resolve payment disputes. It also contains other provisions impacting group health plans, as explained below.

The *No Surprises Act* applies to both fully insured and self-funded group health plans, including grandfathered plans (referred to below as "Plan" or "Plans"). It does not appear to apply to excepted benefits (such as Employee Assistance Programs). The provisions in the *No Surprises Act* are very complex, and more guidance will be needed from the Departments of Labor, Treasury and HHS with regard to its implementation. Below is a high-level overview of its key provisions.

Preventing Surprise Medical Billing (Applies to plan years beginning on and after January 1, 2022)

Participants will be protected from surprise medical bills that could arise from OON emergency care, certain ancillary services provided by OON providers at an in-network facility (e.g., an anesthesiologist), and OON care provided at in-network facilities without the patient's informed consent.[1] For these services, a participant will be required to pay only the in-network cost-sharing amount, which must be applied to the participant's deductible and out-of-pocket maximums (OOPM) under the Plan. Providers will not be able to "balance bill" participants for the remaining amounts.[2]

Air Ambulance Claims. If a Plan covers in-network air ambulance services, then participants can only be required to pay the in-network cost-sharing amount for an air ambulance, and those amounts paid will be applied to the participant's deductible and OOPM under the Plan. Air ambulance providers will not be able to balance bill participants for the remaining amounts. Plans will be required to provide detailed reports on air ambulance claims to the federal government. Note: This provision does not apply to ground ambulance claims.

Independent Dispute Resolution. For the OON claims described above, the Plan must make initial payment or issue a denial to the provider within 30 days of receiving the provider's bill. If there is no agreement on the amount owed, the OON claim may be submitted to arbitration initiated by the Plan or the provider (referred to as "Independent Dispute Resolution").[3] The party who loses at arbitration must pay the entire cost of arbitration.

TH COMMENT: While in most cases the participant will only be paying the in-network costs, the Plan will be paying the OON costs. This will increase Plan costs. The idea behind this, beyond protecting individual consumers, may be that the Plan is in a better position to negotiate these large OON bills; so over time, these OON costs may come down.

ACTION ITEMS:

- For self-funded plans with third-party administrators (TPAs), agreements must be revised to include the quick payment/denial provisions, payment of arbitration costs, and the reporting requirements for air ambulance services.
- For both insured and self-funded plans, begin discussion with insurers/TPAs to determine the expected increase in cost due to these new requirements.

- Plan documents and Summary Plan Descriptions (SPDs) will need to be revised to include these new provisions.

Other Provisions in the No Surprises Act

Transparency Regarding In-Network and OON Deductibles and Out-of-Pocket Limits (Effective for plan years beginning on or after January 1, 2022). A physical or electronic identification card for Plan coverage must disclose:

- In-network and out-of-network deductibles;
- Any OOPM for the Plan coverage; and
- A telephone number and website address through which an enrollee may seek assistance (e.g., information related to in-network hospitals and urgent care facilities).

ACTION ITEM: Plan sponsors will need to ensure that agreements with an insurance carrier and/or TPA require compliance with this new rule.

Protections Against Provider Discrimination (Effective Date Not Known). The Patient Protection and Affordable Care Act (ACA) contained a provision that prohibited discrimination against "any willing provider." The applicable agencies never issued regulations implementing this provision, and instead stated that the statutory language was sufficiently clear. Congress apparently did not agree, as the CAA requires that the agencies propose regulations no later than January 1, 2022, and issue final regulations no later than six months after comments are received. It is unclear what this will mean for Plans.

Advanced Explanation of Benefits, if Requested, for Scheduled Services (Effective for plan years beginning on or after January 1, 2022). Upon request, Plans must send participants an advanced explanation of benefits (EOB) before scheduled care. In most cases, this advanced EOB is due at least 3 business days before such service is to be furnished, but not later than 1 business day after the date of such scheduling.[4] This EOB must include a list of information including,

- whether or not the provider or facility is in-network;
  - if in-network, the contracted rate under the Plan for such services (based on billing and diagnostic codes);
  - if out-of-network, a description of how the individual can obtain information on in-network providers of those services;
- a good faith estimate of the cost received by the provider or facility based on the billing and diagnostic codes;
- the amount the Plan is responsible for paying;
- a good faith estimate of the amount of any cost-sharing the enrollee must pay;
- a good faith estimate of the amount the enrollee has incurred toward meeting the limit of financial responsibility under the Plan (i.e., the deductible and OOPM);

- in the case of a service subject to medical management techniques (e.g., step therapy, prior authorization), a disclaimer that the service is subject to medical management; and
- a disclaimer that the information is only an estimate and subject to change.

TH COMMENT: This advanced EOB will provide participants with insight on the additional costs that come with using an OON provider.

ACTION ITEMS:

- Plan sponsors will need to ensure that their TPA and/or insurance carrier will comply with these requirements. Agreements for self-funded plans must be updated to include advanced EOBs, and should specify which entity is responsible for penalties and costs associated with not providing this advanced EOB (or providing incorrect information).
- The TPA or plan sponsor should also consider how the method for requesting these advanced EOBs will be communicated to participants, including a statement that the information is only an estimate and could change.

Continuity of Care (Effective for plan years beginning on or after January 1, 2022). For a "continuing care patient" who is receiving certain types of in-network care, the Plan must provide 90 days of continued in-network coverage to the participant if his/her treating in-network provider leaves the network (or 90 days from the date that the participant is no longer a continuing care patient, whichever is earlier). A continuing care patient is a person who is: (1) undergoing a course of treatment for a serious and complex condition from the provider or facility; (2) undergoing a course of institutional or inpatient care from the provider or facility; (3) scheduled to undergo nonelective surgery from the provider; (4) pregnant and undergoing a course of treatment for pregnancy from the provider; or (5) determined to be terminally ill and is receiving treatment for such illness from the provider or facility. This requirement does not apply to for-cause terminations of a provider.

TH COMMENT: This will have a cost impact on the Plan. While the participant is only paying the in-network costs, the provider will be OON — and the Plan must pay the additional OON costs.

ACTION ITEMS:

- Understand how the TPA or carrier will communicate this to impacted enrollees;
- Update the SPD to explain this rule; and
- Understand the cost impact of this rule.

Price Comparison Tool (Effective for plan years beginning on or after January 1, 2022). A Plan must offer price comparison guidance by phone and also make available on the Plan website a price comparison tool that allows a Plan enrollee to compare the amount of cost-sharing that an individual would be responsible for paying with respect to a specific item or service — factoring in Plan year, geographic region and participating providers.

TH COMMENT: Plan sponsors may believe that the TPA or insurance carrier already has this kind of tool. However, we do not believe that most of the current price comparison tools includes information for all services.

ACTION ITEMS:

- Determine how any comparison tool currently offered by a TPA or carrier must be updated to comply with this requirement, and the costs associated with that update; and
- Update TPA agreements to address who is responsible for major errors contained in the tool, and specify what kind of disclaimer language should be included with the price comparison tool.

Provider Directories (Effective for plan years beginning on or after January 1, 2022). Plans must ensure that their in-network directories are up-to-date (and can be relied upon) and that participants can access the directory online or by phone. The Plan must include a process for verifying the accuracy of the provider information in-cluded in the directory at least every 90 days, and have a procedure in place for removing a provider or facility if the Plan has been unable to verify the provider or facility's information. If a participant requests information via phone regarding whether a provider is in-network, the Plan must respond in writing (or electronically — as preferred by the participant) within one business day (and this communication must be maintained in the individual's file for at least 2 years).

The Plan must also establish a database on the public website of the Plan (or issuer) that contains a list of each provider and facility that has a direct or indirect contractual relationship with the plan; and directory information (name, address, specialty, phone number and digital contact information for the provider). A participant who relies on any inaccurate provider directory information will be responsible for only the in-network cost-sharing amount.

TH COMMENT: Again, this can create increased costs for the Plan. An error relied on by the participant means that he/she will only be paying the in-network cost sharing, but the Plan will be paying an OON bill.

ACTION ITEMS:

- TPA agreements will need to be revised to include this service, as well as a provision indemnifying the Plan against any additional costs due to an error in the directory.
- The TPA agreement should specify that the TPA will maintain the response communication for the required period, and that any such documentation will be provided to the next TPA.

Additional Transparency Requirements in the CAA

As noted above, in addition to the *No Surprises Act*, the CAA contained a number of separate provisions that are also intended to increase transparency regarding costs and coverage. These requirements are explained below.

Removal of Gag Clauses (appears to be effective now)

Plans cannot enter into any agreement with healthcare providers, network of providers, TPAs or others who offer access to a network of providers, if that contract would, directly or indirectly, preclude the Plan from:

- disclosing provider-specific cost or quality-of-care information or data, through a consumer engagement tool or other means, to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees;
- electronically accessing de-identified claims information (in accordance with HIPAA, GINA and the ADEA); and
- sharing the above information with a business associate.

The agreement can allow the provider or network to include reasonable restrictions on public disclosure of the information. The Plan must submit an annual attestation to HHS that the plan is in compliance with these requirements.

TH COMMENT: Gag clauses are in many TPA agreements. For example, the TPA agreement may state that the Plan will pay at the "PPO Rates" but those rates and how they are determined are categorized as "proprietary information" or "confidential information."

ACTION ITEM: Closely review TPA agreements for gag clauses, which must be removed.

Information about Direct and Indirect Compensation (Applies to contracts that are executed or renewed on and after December 27, 2021)

The ERISA prohibited transaction rules limit the types of transactions that an ERISA plan can enter into with a "party in interest" (which includes service providers). There is an exemption under ERISA Section 408(b)(2) that allows a plan to pay "reasonable compensation" to a party in interest. There are specific regulations implementing ERISA Section 408(b)(2) for retirement plans, but not for health and welfare plans. The CAA has now added specific disclosure requirements for group health plans so that a contract for brokerage services[5] or consulting[6] will only be considered "reasonable" if certain disclosures are made by the service provider to the plan. This requirement only applies to contracts where the service provider reasonably expects to receive $1,000 or more in compensation (direct or indirect) in connection with providing the services. Specifically, these rules will require the disclosure of, among other things, whether the service provider will provide fiduciary services, the direct and indirect compensation received by brokers and consultants related to the health plan, such as for steering plans to certain vendors. For example, a consultant may receive a commission or production bonus from a TPA for the placement of business with that TPA. This type of compensation must now be disclosed to the plan sponsor. It is notable that this new rule does not apply to insurance carriers or pharmaceutical benefits managers (PBMs).

This information must be disclosed to the responsible plan fiduciary before the contract is entered into, extended or renewed. The plan fiduciary must be notified of any change to the required disclosures no later than 60 days from the date that the service provider is informed of the change. There is a good faith reliance standard in the rule for the responsible plan fiduciary, but it must take reasonable steps to obtain missing information and correct any incorrect information

upon discovery. If that fails, the plan fiduciary must provide notice to the DOL (containing specific information) and consider terminating the contract.

It appears that this rule applies only if ERISA plan assets are used. If the plan is funded by a trust, then in most cases ERISA plan assets will be used. What if there is no trust? Note that participant contributions are plan assets. Generally, plan assets must be held in trust. However, if the *sole* reason that a plan would be considered funded (and need a trust) is the presence of participant contributions under a cafeteria plan, the plan will be deemed to be unfunded for trust purposes (DOL Technical Release 92-01). This does not mean that there are no plan assets. Rather, the DOL Technical Release says that the DOL will not enforce the trust requirement solely because there are participant contributions.

Example: Assume that there is no trust, the health plan is fully-insured and part of the premiums are paid by participants. Also assume that the broker is paid commissions from the insurance carrier for the placement of that plan. Are plan assets involved because the commission is likely paid based on the insurance premium payments — which are in part paid by participant contributions (plan assets)? We believe the answer is yes. For a self-funded plan that does not have a trust, what if certain administrative costs are used in determining the premium — are plan assets involved? Again, we believe that the answer is yes.

We expect that the DOL will issue detailed regulations about this rule.

TH COMMENT: Guidance from the DOL will be critical because we are concerned that brokers and consultants may try to claim that all costs are paid by the employer and no plan assets are involved. When similar rules were issued for retirement plans, it was the basis for many class action lawsuits regarding unreasonable costs and fees paid by plan assets, so it will be important for plan sponsors to understand the amount of indirect compensation paid to these providers.

ACTION ITEMS:

- Locate and review all broker and consultant agreements with the group health plan and determine when they renew; and
- Begin discussions with brokers and consultants regarding these provisions and the necessary changes that will need to be made to the agreements.

Mental Health Parity and Addiction Equity Act —Transparency (Effective February 10, 2021)

Health plans that provide both medical/surgical benefits and mental health/substance abuse benefits, and which impose nonquantitative treatment limitations (NQTLs) on mental health/substance abuse benefits, must perform and document a detailed comparative analysis. This analysis must be made available to a state authority, DOL or HHS beginning 45 days after the enactment of the CAA (February 10, 2021), but only upon request from one of those agencies. We believe that a request by a government agency for this documentation will likely be triggered by a participant complaint.

The CAA contains detailed and specific rules about what must be contained in the comparative analysis. If the applicable agency reviews the comparative analysis and determines that the plan

is not in compliance, the plan must specify the actions it will take to be in compliance and, within 45 days, provide the agency with a new comparative analysis that demonstrates compliance. Following the 45-day corrective action period, if the applicable agency makes a final determination that the plan is not in compliance, then not later than 7 days after such determination, the agency shall notify all individuals enrolled in the plan that the plan is not in compliance.

TH COMMENT: The comparative analysis requirements in the CAA are long and complicated. The plan sponsor must ensure that it has entered into a contract with a vendor that can complete this analysis in the timeframes required. A failure to meet these rules will cause the agency to inform all participants of the plan's non-compliance — which we believe will likely lead to class action lawsuits against the plan.

ACTION ITEMS:

- Ensure that the plan has a vendor that will provide this comparative analysis.
- Be prepared to respond to a request for documentation.

Reporting on Drug Prices (effective December 27, 2021, and each June 1 thereafter).

Group health plans must provide to the Departments of Labor, Treasury and HHS certain information regarding costs associated with the plan's prescription drug benefit. The first report will be due by December 27, 2021, and subsequent reports will be due no later than June 1 of every subsequent year. The information that must be included in this report includes:

1. the beginning and end dates of the plan year;
2. the number of participants and beneficiaries,
3. each state in which the plan is offered
4. the 50 brand prescription drugs most frequently dispensed (including number of paid claims for those drugs),
5. the 50 most costly prescription drugs by annual spend (including the annual spend amount for those drugs),
6. the 50 prescription drugs with the greatest increase in plan expenditures,
7. information about the total spending on health care services,
8. the average monthly premium paid by employers and employees,
9. the impact on premiums of rebates, coupons, other similar renumeration paid by drug manufacturers to the plan; and
10. any reduction in premiums and out-of-pocket costs associated with rebates, fees or other remuneration described in #9.

The CAA requires that HHS make available on its website a report on prescription drug reimbursements under health plans, prescription drug pricing trends, and the contribution of prescription drug costs to premium increases or decreases under such plans. This information is to be aggregated in a way that no plan-specific information will be made public.

TH COMMENT: This is a game changer. A plan sponsor should use this information in any future request for proposal (RFP). It should also use this information to revise what it pays for current prescription drugs — and even which prescription drugs are included on the formulary. We expect that plaintiffs' lawyers will also be looking carefully at this data as a basis for class action lawsuits. Many plans have a high deductible which must be paid before most plan coverage begins. Plaintiffs' lawyers may be looking for information to determine if participants are grossly overpaying for prescription drugs prior to reaching the deductible.

ACTION ITEM: Agreements with TPAs and PBMs will need to be revised to include this reporting service.

Transparency in Coverage Regulations — Separate from the CAA

Prior to the passage of the CAA, the Departments of Labor, Treasury and HHS issued final regulations regarding transparency of health plan costs. For group health plans there are two main aspects of the regulations that are explained below. Note that these rules do not apply to excepted benefits (such as vision or dental), retiree-only plans or grandfathered plans.

These new rules include a safe harbor for sponsors of fully insured plans if there is a written agreement with the health insurer to provide this information. There is not any similar relief for self-funded health plans.

Negotiated In-Network and Out-of-Network Allowed Amounts (Effective for plan years beginning on and after January 1, 2022). Plans must publicly post three machine-readable files:

#1 *In-Network File* — All applicable rates (negotiated rates and fee schedules) with in-network providers

#2 *Out-of-Network Allowed Amount File* — Data outlining the historical allowed amounts for covered items and services provided by OON providers

#3 *Prescription Drug File* — Negotiated rates and historical net prices for prescription drugs furnished by in-network providers

This information must be updated monthly and made publicly available on the plan's website free of charge. Individuals should be able to access the files without having to log-in. The rule includes specific requirements for each file.

TH COMMENT: First, this obligation is a huge burden on plans. Plan sponsors should be looking for vendors that can fulfill this obligation. Second, this is a game changer. This will be the first time that a plan sponsor will be able to obtain data on what other plan sponsors are paying for these services. This should, in the long run, bring down health plan costs. Plan sponsors are currently flying blind in RFPs, not knowing what the price should be for services. Plan sponsors are currently in a cycle in which the TPA or insurance carrier proposes highly marked-up prices and the plan sponsor tries to negotiate those down. The amount of the price decrease that can be negotiated is usually based primarily on the size and sophistication of that plan sponsor. Hopefully, access to this kind of database will break that cycle and provide plan sponsors with an advantage in future negotiations with service providers.

ACTION ITEM: TPA, insurance carrier and PBM contracts will need to be amended to comply with these new rules, and the negotiation process should begin early in 2021.

Disclosure of Cost Information (phased in over time, starting with plan years beginning on and after January 1, 2023). Upon request by an enrollee, health plans must disclose estimates of cost-sharing for covered healthcare items and services from a particular provider. The goal is to enable enrollees to obtain an estimate of out-of-pocket expenses in advance of the services. This will be phased in over time. This information must be first available for a specific list of 500 items and services as of January 1, 2023, with information for all items and services as of January 1, 2024.

Plans must disclose the cost-sharing estimates through a user-friendly online service tool and also paper. This information is only available to current enrollees. The tool should provide information for a specific in-network provider or all in-network providers. The tool should take into account different cost-sharing based on multi-tier networks and place-based settings (such as outpatient versus a hospital). The tool must also include the ability to search for OON services and providers.

An enrollee may request that this be in paper form, limited to information for up to 20 providers per request, and the information must be mailed or emailed within 2 business days of the request.

There are seven content elements that must be disclosed on request:

- Estimated cost-sharing liability based on actual rates, allowed amounts, and individual-specific cost-sharing limits (can provide a range)
  - Does not include premiums or balance billing for OON
- Accumulated amounts
  - The amount that the individual has already paid towards the plan's deductible and OOPM
  - Reflect any progress towards reaching a treatment limit (such as number of therapy visits)
- In-network rates for covered items and services
  - This is required even if that rate does not impact the individual's cost-sharing liability
  - For prescription drugs, it is the negotiated rate (not required to disclose the rebates, discounts, or price concessions)
- Out-of-Network Allowed Amounts
- Items and services content list for a bundled payment
  - This is a list of all of the items and services reflected in the cost-sharing estimate for a bundled payment
- A notice of prerequisites to coverage
  - Such as prior authorization or step-therapy
- Disclosure notice

ACTION ITEMS:

- Understand the requirements of these rules;
- Determine who within the organization will be responsible for ensuring that the plan sponsor has engaged the vendors needed for it to comply with these rules; and
- Create a budget for compliance with these rules.

Conclusion

These rules have gone a bit under the radar. All of the above rules were issued in 2020 (prior to Joe Biden becoming President), but it was late in the year when the nation was focused on COVID-19, the holidays and the Presidential election. We believe that these rules will have a significant impact on health plan coverage — more than anything else we have seen since the passing of the ACA. It is a heavy lift for plans for the next few years. Plan sponsors should be sure that they have a basic understanding of the rules so that they can create workstreams and budgets as soon as possible in 2021.

---

[1] There is an exception for nonemergency services provided by OON providers at in-network facilities if the patient knowingly and voluntarily agrees to use the OON provider. In that circumstance, the provider is obligated to notify the patient prior to the scheduled services regarding estimated cost and identifying available in-network options. The "knowing and voluntary consent exception" will not apply if: (1) there is no in-network provider available in the facility; (2) the care is for unforeseen or urgent services; or (3) the provider is an ancillary provider that a patient typically does not select (e.g., a radiologist or anesthesiologist).

[2] Currently, OON providers often "balance bill" participants the difference between the amount paid by the participant's group health plan and the amount charged by the provider. These balance-billed amounts can be very substantial.

[3] Insured group health plans may be subject to state laws that regulate the way certain OON claims are resolved. If a state does not have such a law, then the provisions in the CAA will apply. The provisions in the CAA will apply to self-funded group health plans.

[4] In the case of a service scheduled at least 10 business days before the service is performed, the EOB must be furnished not later than 3 business days after the date of the scheduling or request.

[5] The new rule applies to brokerage services provided to an ERISA group health plan with respect to the selection of, among other things, insurance (including vision and dental), recordkeeping services, medical management vendors, benefits administration, stop-loss insurance, and pharmacy benefits management services.

[6] The new rule applies to consulting services provided to an ERISA group health plan related to, among other things, the development or implementation of plan design, insurance selection, and recordkeeping.

EMAIL MARY POWELL