Updated for delayed provisions in 8/20/2021 FAQ and Proposed Rules issued 9/10/2021

NEW REQUIREMENTS FOR GROUP HEALTH PLANS

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AGENDA

No Surprises Act

- Preventing Surprise Medical Billing
- Air Ambulance Claims
- Independent Dispute Resolution
- Transparency Regarding In-Network and OON Deductible and Out-of-Pocket Limits
- Protections Against Provider Discrimination
- Advanced Explanation of Benefits, if Requested, for Scheduled Services
- Continuity of Care
- Price Comparison Tool
- Provider Directories

Additional Transparency Requirements in the CAA

- Removal of Gag Clauses
- Information about Direct and Indirect Compensation
- Mental Health Parity and Addiction Equity Act —Transparency
- Reporting on Drug Prices

Transparency in Coverage Regulations — Separate from the CAA

- Negotiated In-Network and Out-of-Network Allowed Amounts
- Disclosure of Cost Information

Review and Conclusions

INTRODUCTION

- 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 two main categories:
  - reducing Out-of-Network (OON) costs for enrollees, and
  - providing transparency regarding costs.
- 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 webinar will also provide an overview of these new rules.
- The No Surprises Act is part of the CAA
- The Transparency in Coverage regulations stemmed from an Executive Order that was enabled through the ACA of 2010

INTRODUCTION

- 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.
- Certain Action Items for plan sponsors are included throughout this webinar, 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.

INTRODUCTION

Why is compliance important?

- For group health plans, the penalty for non-compliance will be up to $100 per participant per day
- The noncompliance period is the period running from the date the failure first occurs until the date the failure is corrected.
- The penalty is excused if the failure is not discovered after exercising reasonable diligence or if it was due to reasonable cause and not willful neglect and is corrected within the 30-day period following the date the responsible party knows or should know of the failure.

Reference: 26 U.S. Code § 4980D - Failure to meet certain group health plan requirements https://www.law.cornell.edu/uscode/text/26/4980D

INTRODUCTION

Compliance Responsibility for Penalties

	Insured Group Health	Self-Funded Group Health	Individual/Insured Student Health	Self-funded Student Health
No Surprises Act				
Responsible Party	Uncertain	Employer	Uncertain	Uncertain
Applicability	Yes	Yes	Yes	Uncertain
Enforcement	State, then HHS	HHS, DOL, IRS	State, then HHS	Uncertain
Subject to Penalties	Uncertain	Employer	Uncertain	Uncertain
Transparency				
Responsible Party	Uncertain	Employer	Uncertain	Uncertain
Applicability	Yes, except GF Plans	Yes, except GF Plans	Yes	Uncertain
Enforcement	HHS, DOL, IRS	HHS, DOL, IRS	State, then HHS	Uncertain
Subject to Penalties	Uncertain	Employer	Uncertain	Uncertain

INTRODUCTION

Compliance Responsibility for Penalties

	Insured Group Health	Self-Funded Group Health	Individual/Insured Student Health	Self-funded Student Health
MHPAEA				
Responsible Party	Insurer	Employer	Insurer	MEC Plan Sponsor
Applicability	Yes	Yes	Yes	Maybe
Enforcement	State, then HHS	HHS, DOL, IRS	State, then HHS	State, perhaps
Subject to Penalties	Uncertain	Employer	Uncertain	Uncertain
Fee Disclosure				
Responsible Party	Service Provider[1]	Service Provider[1]	Insurer	Uncertain
Applicability	ERISA Plans	ERISA Plans	Yes	Uncertain
Enforcement	DOL	DOL	HHS	Uncertain
Subject to Penalties	Service Provider[1]	Service Provider[1]	Uncertain	Uncertain

[1]Service provider for fee disclosure includes brokers, consultants, administrators, not insurers or PBMs

THE NO SURPRISES ACT

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 later.
- The No Surprises Act applies to both fully insured and self-funded individual and group health plans, including grandfathered plans (referred to below as "Plan" or "Plans").
- It does not apply to excepted benefits (such as Employee Assistance Programs).
- The provisions in the No Surprises Act are very complex, and guidance has been issued on July 1 from the Departments of Labor, Treasury and HHS with regard to its implementation.

- https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf

THE NO SURPRISES ACT

- Three types of out-of-network claims subject to the No Surprises Act
  - Air Ambulance Claims
  - Emergency Services
  - Non-emergency services by out-of- network provider at an in-network health facility

THE NO SURPRISES ACT

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
- 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 except in cases where a notice and consent is allowed for certain non-emergency services.

SC75

Regulations issued on 9/10/2021, required to submit reports to Agencies by 3/31/2023, contact us for details

THE NO SURPRISES ACT

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.

SC75

The Act also requires plans to submit reports related to air ambulance services to HHS, jointly with the DOL and Treasury Department, by March 31, 2023. A second report will be due by March 30, 2024. The air ambulance data reporting rules apply for two years.

Under the proposed rules, the claims data about air ambulance services would include:

- Whether the services were provided on an emergent or non-emergent basis.
- Whether the provider of such services is part of:
  - a hospital-owned or sponsored program;
  - a municipality-sponsored program;
  - a hospital independent partnership (hybrid) program or independent program; or
  - a tribally operated program in Alaska.
  - Whether the transport originated in a rural or urban area.
- The type of aircraft used for the transport (that is, a fixed-wing or rotary-wing air ambulance).
- Whether the air ambulance service provider has a contract with the plan or insurer to furnish air ambulance services.
- Other information regarding providers of air ambulance services as specified by the Departments.

Information also would be requested from providers of air ambulance services. For example, this information would include air ambulance base rates, patient-loaded mileage rates, average costs per trip, and reimbursement data for various types of payors (such as insured and self-funded employer health plans, Medicare, and Medicaid).

The proposed regulations would require plans and insurers to submit the required data about air ambulance services on a calendar-year basis. A calendar year would include data for:

- Air ambulance services furnished during the calendar year.
- Services for which payments were made within the calendar year (even if the services were furnished in a different calendar year).

Steve Cyboran, 9/20/2021

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Emergency Services

- Emergency services include certain services in an emergency department of a hospital or an independent freestanding emergency department, as well as post-stabilization services in certain instances.
- Urgent care centers will be considered an independent free standing emergency department, if it is licensed by the state to provide emergency services.

Cost Sharing Impact

- Cost sharing for out-of-network services subject to these protections shall be no higher than in-network levels, must count toward any in-network deductibles and out-of-pocket maximums, and balance billing is prohibited.

THE NO SURPRISES ACT

- Out-Of-Network Non-Emergency Services Provided At In-Network Facility
- General rule is that such services may be subject to balance billing if the participant is provided with timely notice and gives written consent.
- Two exceptions where notice and consent may not be used and balance billing will not be allowed:
  - No in-network provider is available for the needed services
  - Certain ancillary services:
    - Pathologists
    - Radiologists
    - Anesthesiologists
    - Assistant surgeons
    - Laboratory and diagnostic tests

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Provider Charges Limitations

- Consumer cost-sharing amounts for claims subject to the No Surprises Ace are determined based on the following amounts:
  - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
  - If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law.
  - If neither of the above apply, the lesser amount of either the billed charge or the qualifying payment amount, which is generally the plan's or issuer's median contracted rate.
- Note that state law will not apply to a self-funded plan unless the plan has opted in to the state law.

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Exceptions to the Provider Charge Limitations

- In limited cases, a provider or facility can provide notice to a person regarding potential out-of-network care and obtain the individual's consent for that out-of-network care and extra costs.
- However, this exception does not apply in certain situations when surprise bills are likely to happen, like for specified ancillary services connected to non-emergency care, such as anesthesiology or radiology services provided at an in-network healthcare facility.
- Surprise billing for items and services covered by the rule generally is not allowed.

THE NO SURPRISES ACT

No Surprises Act Notice Requirements

- Certain health care providers and facilities and health plans must make publicly available, post on a public website, and provide to individuals a one-page notice about:
  - The requirements and prohibitions applicable to the provider or facility under Public Health Service Act sections 2799B-1 and 2799B-2 and their implementing regulations.
  - Any applicable state balance billing limitations or prohibitions.
  - How to contact appropriate state and federal agencies if someone believes the provider or facility has violated the requirements described in the notice.

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Independent Dispute Resolution (Regulations due in December)

- 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").
- The party who loses at arbitration must pay the entire cost of arbitration.

THE NO SURPRISES ACT

Independent Dispute Resolution (Regulations due in December)

- 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.

THE NO SURPRISES ACT

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.
- Providers and medical facilities will have to provide a notice detailing the new no surprises requirements,
- Providers have to obtain the participant's consent before balance billing

Need to make good faith effort to comply.

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.

THE NO SURPRISES ACT

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.

Delayed enforcement date to January 1, 2023

THE NO SURPRISES ACT

Advanced Explanation of Benefits, if Requested, for Scheduled Services (Effective for plan years beginning on or after January 1, 2022).

- Plans or the insurer 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.

Delayed enforcement date to January 1, 2023

THE NO SURPRISES ACT

Advanced Explanation of Benefits, if Requested, for Scheduled Services (Effective for plan years beginning on or after January 1, 2022).

- 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

Delayed enforcement date to January 1, 2023

THE NO SURPRISES ACT

Advanced Explanation of Benefits, if Requested, for Scheduled Services (Effective for plan years beginning on or after January 1, 2022).

- 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.

THE NO SURPRISES ACT

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:
  - undergoing a course of treatment for a serious and complex condition from the provider or facility;
  - undergoing a course of institutional or inpatient care from the provider or facility;
  - scheduled to undergo nonelective surgery from the provider;
  - pregnant and undergoing a course of treatment for pregnancy from the provider; or
  - 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.

THE NO SURPRISES ACT

Continuity of Care (Effective for plan years beginning on or after January 1, 2022).

- 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.

Delayed enforcement to January 1, 2023

THE NO SURPRISES ACT

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.
- 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.

THE NO SURPRISES ACT

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 included 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 NO SURPRISES ACT

Provider Directories (Effective for plan years beginning on or after January 1, 2022).

- 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.
- 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.

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Provider Directories (Effective for plan years beginning on or after January 1, 2022).

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

Effective December 27, 2020, Reporting begins in 2022

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

Removal of Gag Clauses (Effective for plan years beginning on or after January 1, 2022).

- 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.

Effective December 27, 2020, Reporting begins in 2022

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

Removal of Gag Clauses (Effective for plan years beginning on or after January 1, 2022).

- 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.
- 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, network managers, and provider agreements for Gag Clauses, which must be removed.

SC76

Regulations issued on 9/10/2021, contact us for details

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

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

- The CAA has now added specific disclosure requirements for group health plans so that a contract for brokerage services or consulting 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).

SC76

Health insurers offering individual and short-term health insurance coverage are required to disclose to enrollees and to the HHS all direct and indirect compensation provided to agents and brokers associated with plan selection and enrollment.

For this purpose, direct and indirect compensation are defined to cover all forms of consideration that may be transferred between an insurer and its agent or broker, regardless of how that consideration is transferred. Direct compensation under the proposed regulations would include amounts that are:

- Paid by an insurer to an agent or broker for the sale, placement, or renewal of STLDI or an individual health insurance policy.
- Directly attributable to an insurance policy, certificate, or insurance contract (including sales and base commissions).

Examples of indirect compensation would include:

- Service fees, consulting fees, and finders' fees.
- Profitability and persistency bonuses.
- Awards, prizes, and volume-based incentives.
- Non-monetary forms of compensation.

These required disclosures would include:

- The commission schedule for determining the compensation owed to an agent or broker as part of the appointment contract between the insurer and the agent or broker.
- The structure of compensation not captured on the commission schedule.

For new (initial) enrollments, the disclosures would need to:

- Be made before a potential policyholder finalizes plan selection.
- Include documentation confirming the initial enrollment, for example:
  - enrollment documentation required under federal or state law; or
  - an initial enrollment package.

To the enrollee – The insurer must disclose prior to the individual finalizing plan selection and include the disclosure on any documentation confirming enrollment.

To the HHS –

Steve Cyboran, 9/20/2021

Regulations issued on 9/10/2021, contact us for details

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

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

- 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?
- Rather, the DOL Technical Release says that the DOL will not enforce the trust requirement solely because there are participant contributions.

Regulations issued on 9/10/2021, contact us for details

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

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

- Individual Market Coverage (Including Student Health Insurance) Disclosure Provision
- CAA requires health insurers offering individual and short-term health insurance coverage to disclose to enrollees and to the HHS all direct and indirect compensation provided to agents and brokers associated with plan selection and enrollment.
  - To the enrollee – The insurer must disclose prior to the individual finalizing plan selection and include the disclosure on any documentation confirming enrollment.
  - To the HHS – The insurer must report annually, prior to open enrollment.
- The fee disclosure rules do not seem to apply to group health plans that are non-ERISA (public sector and church plans)

Regulations issued on 9/10/2021, contact us for details

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

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

- 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.

Regulations issued on 9/10/2021, contact us for details

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

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

- Guidance from the DOL will be critical because there is a concern 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.

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

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 that 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.

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

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

- 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 service provider or advisor 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 conducts a comparative analysis.
- Be prepared to respond to a request for documentation.

Delayed enforcement to December 27, 2022

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

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

- Group health plans and health insurance issuers of group and individual coverage 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:
  - the beginning and end dates of the plan year;
  - the number of participants and beneficiaries,
  - each state in which the plan is offered
  - the 50 brand prescription drugs most frequently dispensed (including number of paid claims for those drugs),
  - the 50 most costly prescription drugs by annual spend (including the annual expenditure amount for those drugs),

Delayed enforcement to December 27, 2022

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

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

- The information that must be included in this report includes:
  - the 50 prescription drugs with the greatest increase in plan expenditures,
  - information about the total spending on health care services,
  - the average monthly premium paid by employers and employees,
  - the rebates, coupons, other similar remuneration paid by drug manufacturers to the plan; and
  - any reduction in premiums and out-of-pocket costs associated with rebates, fees or other remuneration described above.
- 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.
- The Departments of Treasury, Labor, and HHS issued and RFI on June 23, 2021 soliciting comments.

Delayed enforcement to December 27, 2022

ADDITIONAL TRANSPARENCY REQUIREMENTS IN THE CAA

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

- 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.

ENFORCEMENT

- The surprise billing and related provisions applicable to group health plans are added to the IRC, (Code), PHSA, and ERISA and will be subject to the same general enforcement structure as the ACA coverage mandates.
- States retain primary enforcement authority over fully insured plans, subject to federal enforcement by HHS if a state fails to substantially enforce a provision. HHS also has jurisdiction over self-funded governmental plans.
- The DOL has enforcement authority over plans subject to ERISA.
- Under the Code, a $100 per day per affected person excise tax may apply in the case of noncompliance by private sector plans and church plans.
  - The penalty may not apply if it is found that the provider, plan, or TPA used good faith efforts to comply.
- Provisions applicable to providers are added to the PHSA and are subject to primary enforcement at the state level and potential federal enforcement.
- The DOL is specifically authorized to coordinate with states and HHS regarding violations of provider requirements for group health plans and conduct investigations as appropriate.

TRANSPARENCY IN COVERAGE REGULATIONS — SEPARATE FROM THE CAA

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.

Enforcement delayed to July 1, 2022

TRANSPARENCY IN COVERAGE REGULATIONS — SEPARATE FROM THE CAA

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:
  - In-Network File — All applicable rates (negotiated rates and fee schedules) with in-network providers
  - Out-of-Network Allowed Amount File — Data outlining the historical allowed amounts for covered items and services provided by OON providers
  - 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.

Enforcement delayed to July 1, 2022

TRANSPARENCY IN COVERAGE REGULATIONS — SEPARATE FROM THE CAA

Negotiated In-Network and Out-of-Network Allowed Amounts (Effective for plan years beginning on and after January 1, 2022).

- 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.

TRANSPARENCY IN COVERAGE REGULATIONS — SEPARATE FROM THE CAA

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.

TRANSPARENCY IN COVERAGE REGULATIONS — SEPARATE FROM THE CAA

Disclosure of Cost Information

- 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)

TRANSPARENCY IN COVERAGE REGULATIONS — SEPARATE FROM THE CAA

Disclosure of Cost Information (phased in over time, starting with plan years beginning on and after January 1, 2023).

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

TRANSPARENCY IN COVERAGE REGULATIONS — SEPARATE FROM THE CAA

Disclosure of Cost Information (phased in over time, starting with plan years beginning on and after January 1, 2023).

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.

REVIEW AND CONCLUSIONS

THE NO SURPRISES ACT

Preventing Surprise Medical Billing

- A participant will be required to pay only the in-network cost-sharing amount. TPA or insurer will be responsible to determined the amount to be paid.

Provision	Applicable Parties	Participant Impact	Comment
Independent Dispute Resolution	Plan sponsor or insurer, TPAs provider	Possibly additional cost sharing if provider wins dispute	If no agreement, then settlement may be made by arbitration
Advanced Explanation of Benefits	Plan sponsor with TPA support or insurer	Better understanding of cost in advance to make better cost decision	Provided if required, includes a list of required information
Price Comparison Tool	Plan sponsor or insurer	Better understanding of cost in advance to make better cost decision	Must provide and most price comparison tools must be updated to include all services
Provider Directories	Plan sponsor or insurer with provider network manager	Protection from network misinformation	Must be accurate and updated every 90 days

THE NO SURPRISES ACT

Preventing Surprise Medical Billing

Provision	Applicable Parties	Participant Impact	Comment
Removal of Gag Clauses	Plan sponsor or insurer with provider network manager	Reduce participant out of pocket costs	Restriction must be reasonable
Information regarding direct and direct Compensation	Plan sponsor, brokers, consultants, TPAs	None	All compensation must be disclosed to plan fiduciary
Mental Health Party and addition Equity Act	Plan sponsor or insurer	May improve coverage	Comparative analysis requirement is long and complicated
Reporting on drug prices	Plan sponsor or insurer, PBMs, TPAs	Better understanding of cost in advance to make better cost decision	Group plans must provide report to governmental agencies each year

TRANSPARENCY IN COVERAGE REGULATIONS — SEPARATE FROM THE CAA

Negotiated In-Network and Out-of-Network Allowed Amounts – Information regarding In-Network, Out-of-Network Prescription Drug costs and rates must be posted on website and updated monthly

Disclosure of Cost Information – Upon request, information must be disclosed regarding cost sharing for covered health care services.

CONCLUSION

- The No Surprises Act and transparency laws require plan sponsors to comply with some of the most burdensome tasks since the ACA.
- Compliance will require a significant amount of time and coordination among plan sponsors, medical insurance carriers, self-funded plan administrators, entities offering medical networks to self-funded plan sponsors, and many other stakeholders to manage and implement the various new processes and requirements.

CONCLUSION

- While it seems evident that the No Surprises Act will lower out-of-pocket costs for participants, it is not clear at this time whether plan sponsors will experience lower overall costs as a result.
- Compliance typically comes with a cost (as outlined in a number of areas above) but it is not certain that these new requirements will produce offsetting claims cost reductions to produce lower total premiums.

CONCLUSION

- Plan sponsors offering mental health or substance abuse disorder benefits, relying on the guidance issued in the FAQs, should already have their comparative analyses ready (or be in the process of analysis) in case they are requested by regulators.
- Most of the other provisions take effect on or after January 1, 2022.
- All plan sponsors need to start working on processes to meet the new informational requirements and specifications for plan ID cards and EOBs, as well as updating plan documents and communication materials.
- For all CAA healthcare provisions, the timeline for compliance is tight and plan sponsors are well-advised to move forward as quickly as possible.

HOW WE CAN HELP

- Conduct webinars and training for clients, employees, and the community
- Release a Compliance Forms Package in August that contains over 30 sample forms, explanations, notices, plan and SPD provisions and compliance guides
- Assist in drafting documents, forms and notices
- Conduct compliance audits
- Conduct financial and cost impact studies
- Coordinate vendor requests and financial reporting
- Support plan design, rate development and contribution strategy to minimize risk of non-compliance
- Support student health strategy, design, rating, self-funding
- Answer ongoing questions

QUESTIONS???????

CONTACT INFORMATION

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LARRY GRUDZIEN
ATTORNEY AT LAW, J.D., L.L.M.

Experience

Lawrence (Larry) Grudzien, J.D., L.L.M. is an attorney practicing exclusively in the field of employee benefits. He has experience in dealing with qualified plans, health and welfare, fringe benefits and executive compensation areas. He has more than 35 years' experience in employee benefit law.

- He has extensive practice advising on all aspects of employee benefit law including: drafting and reviewing individually designed and prototype retirement plans and Employee Stock Ownership Plans (ESOPs), performing due diligence on employee benefit issues for merger, acquisition and outsourcing transactions and advising on administrative and design issues, involving qualified retirement plans, including ESOPs, fringe benefit plans and health and welfare plans

Education and Credentials

- Mr. Grudzien was also an adjunct faculty member of John Marshall Law School's L.L.M. program in Employee Benefits and at the Valparaiso University's School of Law.
- Mr. Grudzien has a B.A. degree in history and political science from Indiana University, a J.D. degree from Valparaiso University School of Law and a L.L.M. degree in tax from Boston University School of Law.
- He is a member of Indiana and Illinois Bars.

HOWARD LAPIN
ATTORNEY AT LAW, C.P.A. ,J.D.

Experience

Howard has 35 years of experience advising clients on taxes, employee benefits and business issues. He has developed and conducted staff training on a variety of benefits compliance issues. He retired from the Segal Company, an employee benefits consulting firm after 23 years, where he was the Compliance Manager and Vice President advising employers and plan administrators on a wide variety of employee benefit issues. Howard was also an attorney at William M. Mercer for over eight years. Howard has helped numerous organizations meet their compliance requirements.

- Conducted HIPAA training for over 100 organizations,
- Assisted numerous clients in addressing issues under the Affordable Care Act,
- Drafted numerous health and welfare plans, including Section 125 Plans,
- Assisted health and welfare plans addressing issues raised during a Department of Labor audit.

Education and Credentials

Howard earned his Juris Doctorate from Chicago-Kent College of Law and a Bachelor of Science from DePaul University. He is also a CPA.

Howard is an adjunct professor at John Marshall Law School, where he developed and taught courses on cash or deferred arrangements and the Affordable Care Act. He is a past chairperson of the Employee Benefits Committee of the Illinois CPA Society.

Presentations

He has presented at over 50 seminars and speeches including the International Foundation of Employee Benefit Plans, Illinois CPA Society, Chicago Bar Association and Lorman Education.

- Understanding the Rules under COBRA-Webinar
- Coronavirus in the Workplace-Webinar
- The Release of Coronavirus Vaccines-Webinar
- Navigating the Legal Obstacles Surrounding Wellness Programs-Seminar
- Discrimination Rules for Qualified Plans-Seminar
- Health and Welfare Plans Legal Update-Seminar

STEVEN CYBORAN, ASA, MAAA, FCA, CEBS
CHIEF BEHAVIOR OFFICER, CONSULTING ACTUARY

Experience

Steve Cyboran is an actuary and innovator around people, rewards and benefits. With a quarter century of consulting experience, he has been actively involved in a variety of strategy projects focusing on a behavioral approach to create a healthy culture, refine the employee value proposition, performance, organization effectiveness, health care, financial well-being, disability, and time-off. These projects include a collaborative approach to drive behavior through the design, administration, and implementation to achieve client objectives.

- Assisted a Midwestern university with the redesign of health care, dental, pharmacy, disability, voluntary benefits, and HR technology, resulting in savings of over $15 million annually through better control of expenditures and without significant benefit reductions.
- Supported a renowned academic medical center with 14,000 employees to standardize time-off and disability programs across eight business units to support the personal renewal of employees, align the programs with total rewards and wellness initiatives, better manage the number of unscheduled absences and disabilities, and differentiate for key talent.
- Supported a health system with 45,000 employees consolidate 100 paid time off programs to align with its healthy culture initiatives and streamline the administration of the programs with metrics measuring success.
- Through the redesign and rollout of leave and disability programs, helped reduce unscheduled absences by 52%, reduce extended absence by 72%, reduce high performer turnover by 29%, increase low performer turnover by 36%, and reduce related employee relations issues by 95%.

Education and Credentials

Steve graduated with distinction from the University of Illinois, Urbana-Champaign with a BS in Mathematics. He is an Associate of the Society of Actuaries, a Member of the American Academy of Actuaries and a Fellow of the Conference of Consulting Actuaries. Mr. Cyboran earned Strategy Culture Alignment Certification by Work-Effects and Outmatch Certified Reseller Certification (Including Pomello Culture tools), and his CEBS designation from the International Society of Certified Employee Benefits Specialists. He is a member of the Society for Human Resource Management. He is also Chicago Chapter former President of the Disability Management Employers Coalition. He is a li-censed Life, Accident and Health agent in Oklahoma, Texas, Kentucky, and New York.

Publications/Presentations/Research

Steve Cyboran has led research, published articles, been quoted in the news or presented over 150 times. Following are a few examples of his work. Visit https://www.cyboran.com/outandabout/ for more examples.

- “The Value of a Healthy Culture: Understanding Benefits, Costs and Achieving Results”, NACUBO
- “PTO in Higher Ed? Absolutely!” Eastern CUPA, Spring Conference
- "Why Should Physicians Work for Your Organization? Physician Alignment through a Magnetic Employee Value Proposition" Cyboran.com
- “Making the Case: New Study Shows It Does Indeed, Pay to Become a Healthy Enterprise," Benefits Quarterly
- “Leveraging an Integrated Health, Absence and Disability Model to Improve Outcomes.” Council on Employee Benefits, Peer 2 Peer Call
- “The Increasing Importance of Benefits Metrics," WorldatWork Podcast

WES ROGERS
CHIEF GUIDANCE OFFICER

Experience

Wes Rogers has over 30 years' experience in consulting and senior management positions with a variety of organizations. Wes has worked with hospital and physician owned health care organizations as a member of senior management and as a consultant to executive teams. This experience provides exceptional insights into the operations of insurance companies and the delivery of healthcare. His specific areas of knowledge and expertise include plan design and business strategy, workforce management and human resources policy development, underwriting and rate setting, regulatory and compliance issues, employee contribution policy development, specific Affordable Care Act (ACA) compliance strategies, RFP design and evaluation, and contract negotiations.

Some of his accomplishments with large university systems include:

- Worked with a retail oil and gas marketing company to develop a comprehensive workforce management policy and ACA hours tracking and reporting system, which allowed them to become ACA compliant and avoid unintended health care eligibility, improved scheduling, and reduced overall hours with the same productivity.
- Developing a comprehensive workforce management policy for a midwestern public university to assure effective workforce management and Affordable Care Act compliance.
- Assisted a northeastern private university to work with the Graduate Student Organization Senate to address key benefits and compensation issues for Graduate Assistants and avert potential collective bar-gaining efforts among graduate student employees.
- Work with the Centers for Medicare and Medicaid Services (CMS) to secure Minimum Essential Coverage (MEC) approval for large, self-funded student health plans.

Wes has a great deal of experience developing effective compliance and workforce management policies for clients with complex employee positions.

Education and Credentials

Wes holds an Associate of Arts degree and a Bachelor of Science degree in Mathematics. Mr. Rogers earned Strategy Culture Alignment Certification by Work-Effects and Outmatch Certified Reseller Certification (Including Pomello Culture tools). He is a licensed Life, Accident and Health agent in Oklahoma, Texas, Kentucky, and New York.

Publications/Presentations

Wes has led presented, written articles, been quoted in the news or presented dozens of times. Following are a few examples of his recent work.

- "Are Your Employee Benefits Really Designed for the "Soil" Your Employees Need?", Humaculture.com
- "Leadership & Tomatoes: 3 Business Principles from My Garden", Humaculture.com
- "Weathering the Storm: Is Your Organizational "Soil" Healthy Enough to Weather Both Floods and Droughts?", Humaculture.com