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Unpacking the Consolidated Appropriations Act – Health and Welfare Plans

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Unpacking the Consolidated Appropriations Act, 2021 Health and Welfare Plans

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Agenda – Comprehensive Health Reform

- Surprise Billing
- Transparency Rules
- Broker/Consultant Compensation Disclosure
- Permitted Cafeteria Plan/Spending Account Changes
- Mental Health Parity Non-Quantitative Treatment Limitation Compliance Requirements
- ACA Transparency in Coverage Final Rule
  - Public Pricing Disclosures - Machine Readable Files
  - Individual Cost-Sharing/Health Plan Coverage – Self-Service Tool

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:
    - Rules similar to ACA apply
  - "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
- Cost sharing counted 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 make initial denial within 30 days
- 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)

Advance EOB Disclosures

- Upon receiving the notice from a provider/facility of a scheduled services or a request from a participant/beneficiary, the plan must:
  - Notify the participant or beneficiary of the following information:
    - Whether the provider/facility is IN
    - If IN, the contracted rate
    - If OON, how to obtain information on network providers
    - Good faith cost estimate of the amount the plan will pay
    - Good faith estimate of the individual's cost share (as of the date of the notice/request)
    - Good faith estimate of the amounts the individual has incurred towards financial limitations (deductible and OOP)
    - If services are subject to a medical management technique, a disclaimer that such services are subject to such medical management;
    - Estimate disclaimer

Continuity of Care

- If IN provider leaves network, plan must allow coverage for services by same provider as prior to termination of participating provider agreement
  - Must provide participant notice of termination of provider's in-network status
  - Must allow continuation of IN care with provider for 90 days
  - Applies to serious and complex conditions, institutional inpatient care, scheduled non-elective surgery, pregnancy, or terminally ill

Additional Requirements

- State All Claim Database Reporting
- Cost sharing on ID cards
- Enhanced Provider Network Directory
- Balance Billing Information on Plan's Website
- Applicable to group health plans and group health insurers
  - Applies to grandfathered and non-grandfathered
  - Does not apply to excepted benefits
  - Does not apply to retiree health plans

Transparency – Removal of Gag Provisions in Agreements

- Effective Date: Date of enactment (December 27, 2021)
- Plan may not enter into an agreement with a third party that would directly or indirectly restrict the plan from:
  - Providing provider specific costs or quality of care information through a consumer engagement tool or any other means to the plan sponsor, enrollees or those eligible to be enrolled;
  - Accessing de-identified information
  - Accessing the following per claim information:
    - Financial information
    - Provider information
    - Service codes
    - Any other data element in claim and encounter information
    - Sharing data with a BAA
  - Third party may place reasonable restrictions on the public disclosure of this information
  - Must be consistent with HIPAA and other privacy requirements

Removal of Gag Provisions

- Annual submission to "Secretary" required by plan affirming compliance
- Applicable to group health plans
  - Both grandfathered and non-grandfathered
  - Does not apply to excepted benefits
  - Does not apply to retiree only health plans
- Penalty for not complying:
  - $100 per day excise tax under 4980D
  - ERISA specific enforcement/fiduciary provisions

Broker/Consultant Compensation Disclosure

- Effective December 27, 2021
- "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

Reporting on Prescription Drug Costs

- Effective December 27, 2021—by June 1 each year thereafter
- Group health plans and issuers must submit reports to HHS, DOL and IRS with the following:
  - Plan Year
  - Number of enrollees, participant and beneficiaries
  - Each state where coverage is provided
  - The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid and total number of claims paid for each drug
  - The 50 costliest drugs in annual spending (and amount spent)
  - 50 drugs with greatest expenditure increase over previous plan year
  - Total spending by plan on health care services by (i) cost type (e.g. hospital costs, health care provider, clinical service costs, prescription drug costs, etc.) (ii) spending on RX by the plan and enrollees/participants/beneficiaries
  - Average monthly premium by employer and participants
  - The impact on premiums from rebates

Further Flexible Spending Account Guidance-Notice 2021-15

- Add on to Section 214 of the Consolidated Appropriations Act which provides flexibility with respect to carryovers of unused amounts from the 2020 and 2021 plan years
- Extends the permissible period for incurring reimbursable claims for plan years ending in 2020 and 2021
- Provides a 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
- Allows certain mid-year election changes for plan years ending in 2021

Rollovers and Grace Periods-Notice 2021-15

- For 2020 and 2021 plan years, cafeteria plans may be amended to permit a Carryover or Grace Period for all or a portion of unused FSA amounts to be rolled over to the subsequent plan year
- Plans can be amended to add Carryovers or Grace Periods even if they did not previously have them, but may not have both a Carryover and Grace Period with respect to the same plan year
- Plans can require employees to enroll in FSAs with a minimum election amount in the subsequent plan year in order to be eligible to access rollover funds
- Grace periods can be up to 12 months, but can be shorter

Annual Limits-Notice 2021-15

- Annual limits apply to amounts contributed and do not include Carryovers or Grace Period amounts
- Amounts contributed to a Dependent Care FSA are required to be reported in Box 10 of Form W-2
- Employers may report in Box 10 for a year the salary reduction amount elected by the employee for the year for dependent care assistance and are not required to adjust the amount reported in Box 10 to take into account amounts that remain available in a Grace Period or Carryover
- Informal guidance provided by the IRS confirms amounts reimbursed to a participant under a Dependent Care FSA in excess of $5,000 for a calendar year due to a Carryover or Grace Period are not treated as taxable income

HSA Compatibility-Notice 2021-15

- Employees enrolled in a General Purpose Health FSA are not eligible to make or receive HSA contributions. This includes participation in a General Purpose Health FSA during a Carryover or Grace Period
- Plans can be amended to convert General Purpose Health FSA to Limited Purpose Health FSA for those employees enrolled in a HDHP/HSA option and can permit employees to opt-out of a Carryover or Grace Period feature to preserve HSA eligibility
- In addition, plans can be amended to allow an employee to make a mid-year election to be covered by a General Purpose Health FSA for part of the year and an HSA-compatible Health FSA for part of the year
- HSA eligibility is measured monthly

Pre-Tax Health Elections- Notice 2021-15

- The Notice also provides additional relief with respect to mid-year elections for employer-sponsored health coverage for plan years ending in 2021:
  - Make a new election on a prospective basis, if the employee initially declined to elect employer-sponsored health coverage;
  - Revoke an existing election and make a new election to enroll in different health coverage sponsored by the same employer on a prospective basis; and
  - Revoke an existing election on a prospective basis, provided that the employee attests in writing that the employee is enrolled, or immediately will enroll, in other health coverage not sponsored by the employer.

Pre-Tax Health Elections- Notice 2021-15 (Continued)

- Problems with Adverse Selection
- Employer can limit elections to circumstances in which an employee's coverage will be increased or improved as a result of the election (for example, by electing to switch from self-only coverage to family coverage, or from a low option plan covering in-network expenses only to a high option plan covering expenses in or out of network).
- Applies to medical, dental and vision only

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

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

- Effective 45 days after the date of enactment- Effective February 10, 2021
- 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 on MH and/or SUD benefits
  - Group health plans must prepare a comparative analysis
  - New mandatory regulatory audits
    - The Regulators will be required to request no fewer than 20 of these comparative analyses per year

ACA Transparency in Coverage Background

- The Departments of Treasury (IRS), HHS (CMS) and Labor (EBSA) jointly issued proposed regulations in November of 2019, in response to Trump Executive Order entitled "Improving Price and Quality Transparency in American Healthcare to Put Patients First"
- Final regulations "**Transparency in Coverage**" were published November 12, 2020 and implement Section 2715A of the Public Health Service Act ("PHS Act") and Section 1311(e)(3) of the Affordable Care Act ("ACA")
- There are varying effective dates
- The final rule has 2 main disclosure requirements: **Public Disclosures** available on the internet and **Plan Participant Disclosures** available through a self-service tool

Group Health Plan Transparency Rules – Two Parts

- Public Pricing Disclosure
  - Plan Years beginning on or after January 1, 2022
  - 3 Sub-parts:
    - In-Network File
    - Out of Network File
    - Prescription Drug File
- Individual Cost Sharing Liability Disclosure
  - Plan Years beginning on or after January 1, 2023 (500 services)
  - Plan Years beginning on or after January 1, 2024 (All services)
  - Cost sharing information
  - Upon request by participant or beneficiary
  - Internet self-service tool/paper

Which Plans are Covered

- **Covered Plans**
  - Self-insured Group Health Plans
  - Fully-insured Health Plans (individual and group markets)
  - Prescription Drug Plans
  - Grandmother plans
- **Non-covered plans**
  - Grandfathered plans
  - Excepted Benefits (e.g., limited scope dental and vision)
  - Retiree-only Plans
  - Account based plans (health FSAs, HRAs, HSAs)
  - Expatriate plans
  - Short-term Limited Duration Insurance

Machine-Readable Files

1	The **first file** must include payment rates negotiated between plans or issuers and in-network providers (excluding information related to prescription drugs that are subject to a fee-for-service reimbursement arrangement which is reported separately)
2	The **second file** must include historical pricing information showing unique allowed amounts and billed charges for covered items and services furnished by out-of-network providers
3	The **third file** must report the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level

Machine-Readable File

- Must be updated **monthly** and include the date of the most recent update
- Technical instructions will be provided in separate guidance
- Accessible **free of charge**, without user account, password, or other credentials, and without having to submit any personal identifying information such as a name or email address

Plan Participant Disclosure - Cost-Sharing Tool

- **Internet-based cost-sharing tool** – "shopping tool" where participants, beneficiaries (and authorized representatives) will be able to see **in advance** the **negotiated rate** between the provider and their plan or insurer, as well as an **out-of-pocket cost estimate** based on their own health plan design for procedures, drugs, durable medical equipment, and other items and services
- The intent is to give consumers of health care accurate **estimates** of their cost-sharing liability for health care items and services from different providers in real time, allowing them to both understand how costs are determined and also to shop and compare health care costs before receiving care

Cost-Sharing Tool

- The **required information** to be provided includes:
  - estimated cost-sharing liability
  - amounts already accumulated toward the covered individual's deductible and out-of-pocket maximum (i.e. deductibles, coinsurance, copays and OOP max)
  - in-network rates
  - out-of-network allowed amounts
  - a list of items and services combined under a bundled payment
  - notice of prerequisites for coverage (such as prior authorization)
  - certain other specific disclosures (such as a reminder of the possibility of balance billing)

Cost-Sharing Tool

500	Plans and issuers must make cost-sharing information available for **500 specified items and services** for plan or policy years beginning on or after January 1, 2023
All	Plans and issuers must make cost-sharing information available for **all covered items and services** for plan or policy years beginning on or after January 1, 2024

Cost-Sharing Tool

- Information must be in **plain language**, without subscription or fee
- Requires **search functionality** for cost-sharing information for a covered item or service by inputting:
  - A billing code (e.g., CPT Code) or a descriptive term (e.g., rapid flu test), at option of user;
  - Name of in-network provider; and
  - Other factors such as location of the service, facility name, or dosage
- Must refine and reorder search based on geography of provider and amount of cost-sharing liability
- Requested information must be provided in paper form, free upon request and mailed no later than 2 business days after request is received; may limit number of providers for cost share information to 20 providers per

Notice Requirements

- **Notice** is required in connection with a request for cost-sharing liability, that includes the following:
  - OON providers may balance bill participants, beneficiaries, or enrollees, and the estimated cost-sharing liability does not account for these potential additional amounts (only required if balance billing permitted under state law)
  - Actual charges for the covered items or services may be different from the estimate, depending on the actual items and services received at the point of care
  - The estimated cost-sharing liability for a covered item or service is not a guarantee that benefits will be provided for that item or service
  - Whether plan counts copay assistance or other 3rd party payments toward deductible and OOP limit
  - An in-network item or service may not be subject to cost-sharing if it is billed as a preventive service

Notice Requirements

- A **model notice** is available on the Department of Labor's website:
- https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-draft-model-disclosure.pdf

What Should Plan Sponsors Do?

- **Fully-insured Plans**
  - Plan satisfies the requirements if the health insurance issuer is required to provide the information pursuant to a **written agreement** between the plan and issuer
  - Insurer is liable if it fails to provide the required disclosures
- **Self-insured Plans**
  - TPAs and specialty vendors will likely do the build out, gather and populate data and maintain the database and files
  - Plan Sponsor ultimately remains liable
  - TPA/PBM Agreement will be important to allocate responsibility and liability
  - Include in RFPs/business plans and cost projections now
  - Mid-term amendments to existing agreements may be required

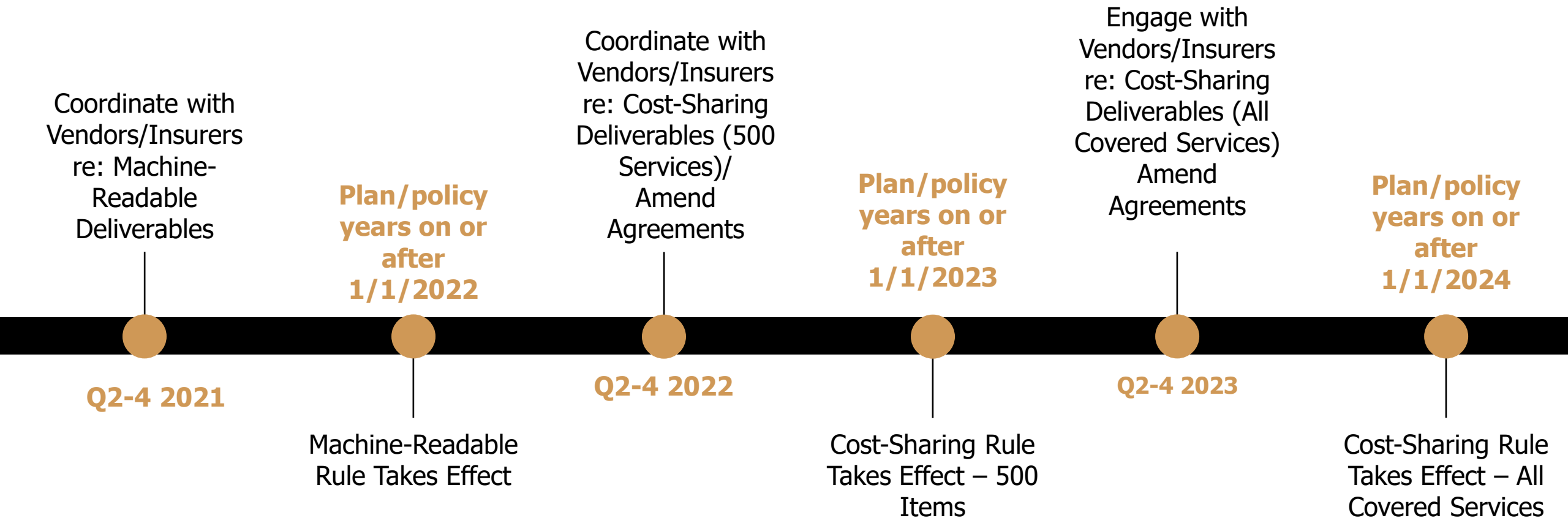
Plan Sponsor Concerns

- **TPA/PBM/Point Solution Agreements**
  - Agreements will need to be amended to cover additional transparency services, pricing disclosures 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
  - Reasonableness of Fees/Pricing
  - Monitoring of Vendors
  - Participant Disclosure Requirements
  - Authorized Representative/Provider Assignment of Benefit Issues
- **Liability/Enforcement**
  - Same enforcement mechanism as ACA – 4980D penalties
  - ERISA concerns:
    - Benefit Claims v. Estimates
    - Disclosure Requirements
    - Fiduciary Breach Liability

Good Faith Reliance

- A plan or issuer will not fail to comply with the disclosure requirements if, while acting in **good faith** and with reasonable diligence:
  - it makes an error or omission and corrects the information as soon as practicable
  - its internet website is temporarily inaccessible, provided it makes the information available as soon as practicable
  - Information supplied by another entity to the plan is inaccurate or incomplete (as long as plan did not know or should not have known)

Plan Sponsor Timeline



Consequences of not complying

- IRC 4980D
  - $100/day excise tax
- ERISA
  - specific performance enforcement by DOL
  - Suits by participants
- PHSA (non-federal governmental plans)
  - Enforcement by HHS
- Good faith compliance standard applies
- Will Biden Administration revise or rescind the rule?

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Amy Gordon focuses her practice on health and welfare benefit compliance, especially with respect to the Health Insurance Portability and Accountability Act (HIPAA), ERISA, the Public Health Service Act, the Internal Revenue Code, the Affordable Care Act (ACA) and its replacement legislation, and related federal and state laws and regulations. She regularly advises clients on structuring and maintaining their self-funded and insured active and retiree health plans, wellness programs, and on-site clinics. She assists clients in negotiating service provider agreements. Amy handles fiduciary issues, including prohibited transactions and other ERISA Title I matters and represents clients before the U.S. Department of Labor, Employee Benefits Security Administration, and the Internal Revenue Service (IRS). She also advises on funding options for plans including Voluntary Employees' Beneficiary Associations (VEBAs) and Captives.

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CAA Benefits Alert: Unpacking the Benefits Provisions in the Consolidated Appropriations Act, 2021 Surprise Billing

Jan 6, 2021

In an unexpected but hard-fought win for consumers of medical care, surprise billing reform was signed into law as part of the $900 billion Consolidated Appropriations Act, 2021. The aptly-named “No Surprises Act” (the Act) is the result of a multi-year, bi-partisan effort to end surprise billing for medical plan participants and hold them harmless from balance billing by out-of-network providers, including federally regulated air ambulances. Under the Act, participants will be protected from surprise medical bills from out-of-network providers for emergency services and non-emergency services at in-network facilities (unless the participant consents to treatment by an out-of-network provider) and will only be liable for cost-sharing amounts that apply to in-network services. The Act also provides for an independent dispute resolution process to facilitate negotiation of outstanding amounts between payors and providers and contains other transparency measures discussed below. These provisions generally apply to plan years beginning on or after January 1, 2022.

BACKGROUND

Medical providers and facilities that are part of a provider network have a contractual relationship with a group health plan, third party administrator (TPA), or insurer (payor) setting forth the negotiated, discounted price for covered items and services. Covered items and services received through these medical providers and facilities are commonly referred to as “in-network benefits.”

Providers and facilities that are not part of a provider network (commonly referred to as “out-of-network providers” and/or “non-participating providers”) lack these contractual relationships. Items and services received through these medical providers and facilities are commonly referred to as “out-of-network benefits.” These out-of-network benefits also typically include participant cost-sharing amounts, but these amounts are not known by the participant up-front, because they are usually based on a percentage of the cost the plan pays the out-of-network provider and any additional amounts not paid by the plan.

Plans will typically have different participant cost-sharing amounts for in-network and out-of-network benefits. Cost-sharing amounts are either in the form of co-payments or co-insurance and for out-of-network benefits the participant will also be responsible for additional fees and expenses charged by

the out-of-network provider or facility that are not covered by the plan. In addition, most plans have separate deductibles and out-of-pocket maximums based on services and items received in-network or out-of-network.

Currently, under most health plans that offer out-of-network benefits, when a participant receives items or services from an out-of-network provider, the out-of-network provider invoices the plan its billed charges (often at higher rates than network pricing) and is reimbursed by the plan for covered expenses based on the plan's out-of-network reimbursement methodology. Such methodologies include maximum allowable amount, reference based pricing, a multiple of the Medicare reimbursement rate or usual, reasonable and customary expenses. The out-of-network provider usually seeks reimbursement for the delta not paid by the plan through other means, such as balance billing the plan participant or attempting to seek additional reimbursement from the plan through the ERISA claims process asserting its standing under an assignment of benefits/designated beneficiary theory. This billing practice has resulted in an increase in plan participant responsibility for unexpected residual medical bills and has exposed plans to an increasing amount of provider lawsuits. While many states have passed legislation aimed at curbing surprise billing, self-insured plans and federally regulated air ambulances were beyond the reach of these laws.

THE NO SURPRISES ACT

The Act, which amends ERISA, the Internal Revenue Code (Code) and the Public Health Security Act (PHSA), requires both fully-insured and self-insured group health plans to hold health plan participants harmless from the impact of surprise medical bills. Under the Act, plan participants are only required to pay the in-network benefit cost-sharing amount for out-of-network benefits for emergency care services, for certain ancillary services provided by out-of-network providers at in-network facilities, and for out-of-network care provided at in-network facilities without the participant's informed consent. The Act also requires that any out-of-network expenses for the services covered under the Act accumulate towards a plan participant's in-network deductible and out-of-pocket maximum. Payment to providers would be based on a payment methodology using a median amount based on in-network rates, including for those services that are not billed on a fee-for-service basis.

The Act contains different rules for emergency and non-emergency services, but accomplishes surprise billing reform by prohibiting out-of-network providers from sending participants balance bills for more than the median in-network cost-sharing amount. With respect to emergency services, the Act requires plans to cover emergency services delivered by hospital emergency departments or certain free-standing emergency facilities without prior authorization at in-network rates. With respect to the delivery of non-emergency services, out-of-network providers are prohibited from balance billing participants unless the provider gives the participant advance written notice and the participant provides consent to receive out-of-network care.

INDEPENDENT DISPUTE RESOLUTION

The Act also provides for an independent dispute resolution process between payors and providers to negotiate and settle out-of-network claims through baseball style arbitration in a binding dispute resolution process known as Independent Dispute Resolution (IDR) administered by independent, unbiased entities with no affiliation to providers or payors. If the parties are unable to resolve their differences during a 30-day open negotiation, the dispute is submitted to the IDR entity. To achieve resolution, the IDR entity is required to consider the median in-network rate, relevant information brought by either party, and information requested by the reviewer, as well as factors such as the provider's training and experience, the complexity of furnishing the item or service, demonstrations of good faith efforts (or lack thereof) to enter into a network agreement, prior contracted rates during the previous four plan years, and other items. Notably, the IDR entity cannot reference Medicare claims data or provider billed charges in determining the negotiated price. There is also a tolling period in

which the party that initiated the IDR may not take the same party to IDR for the same item or service for 90 days following a prior determination. In addition, the losing party must pay the cost of the entire arbitration as an incentive against seeking arbitration for superfluous cases.

AIR AMBULANCE REFORM

Under the Act, plan participants are also held harmless from surprise medical bills from federally regulated air ambulances; note that ground ambulances are not subject to the new law. Participants are only required to pay the in-network cost-sharing amount for out-of-network air ambulances (and such amounts accumulate towards the participant's in-network deductible and out-of-pocket maximum). Air ambulances are prohibited from sending participants balance bills for more than the in-network cost-sharing amount. If a 30-day negotiation period between the parties is not successful, the excess amount is negotiated by the IDR process described above looking at factors such as the training, experience, and quality of the provider, the location where the participant was picked up and the population density of that location, the air ambulance vehicle type and medical capabilities, extenuating factors such as participant acuity and the complexity of furnishing the item or service, demonstrations of good faith efforts (or lack thereof) to enter into a network agreement, prior contracted rates during the previous four plan years, or other information submitted by the parties.

In order to build a reliable reference data base, air ambulance providers are required to submit two years of cost data to the Secretaries of Health and Human Services (HHS) and Transportation (collectively, the Secretaries) and insurers are required to submit two years of claims data related to air ambulance services to the Secretary of HHS so that the Secretaries can publish a comprehensive report.

ADDITIONAL DISCLOSURE REQUIREMENTS FOR HEALTH PLANS

The Act also contains a number of additional disclosure requirements aimed at providing plan participants with transparency as to benefit design and provider networks. Notably, the Act requires group health plans and health insurance issuers to:

- Include on the ID card issued to enrollees, the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitations.
- Provide an advance Explanation of Benefits (EOB) for scheduled services at least three days in advance to give participants transparency into which providers are expected to provide treatment, the expected cost, and the network status of the providers.
- Offer a price comparison tool for consumers (this is in addition to the tool required under the Transparency in Coverage rules finalized earlier this year and discussed in our alert linked here.
- Publish up-to-date directories of the plan's in-network providers, available to participants online, or within one business day of an inquiry. If a participant provides documentation that they received incorrect information from a plan or issuer about a provider's network status prior to a visit, the participant will only be responsible for the in-network cost-sharing amount.

The Act also contains a number of transparency reforms aimed at providers and allows for an external review to determine whether surprise billing protections are applicable when there is an adverse determination by a plan or issuer beginning not later than January 1, 2022.

ENFORCEMENT

The Departments of Labor, Treasury and HHS are tasked with creating a process to audit health plans to ensure they comply with the requirements to apply median in-network rates to out-of-network services. The audits would include both sample audits and targeted audits based on complaints. For

fully-insured health plans (i.e., those funded through insurance), provider enforcement will be largely left to the state. Many states already have surprise billing laws on the books that are not preempted by ERISA with respect to fully-insured health plans. HHS also has the ability to impose penalties on providers of up to $10,000 per violation. For self-insured plans (i.e., those funded by an employer and/or its employees), enforcement will be governed by enforcement rules applicable to group health plans under ERISA, the Code or the PHSA, depending on the type of sponsoring entity.

Winston Takeaway: *Plan sponsors have a lot to do to prepare for these new rules, including updating their plan documents, summary plan descriptions, claim and appeal procedures (including the new advance EOB requirements), summary of benefits and coverage, updating provider directories and member ID cards and preparing for the new IDR process to negotiate disputed bills from out-of-network providers. Plan sponsors will also be required to work with their TPAs and insurers to ensure that they are taking steps to comply with the new rules and preparing for audits.*

This article is part of our "Unpacking the Employee Benefits Provisions in the Consolidated Appropriations Act, 2021" series. Click here for other CAA-related articles. Please contact a member of the Winston & Strawn Employee Benefits and Executive Compensation Practice Group or your Winston relationship attorney for further information.

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WINSTON & STRAWN LLP

CAA Benefits Alert: New Compliance Guidance and MHPAEA Action Items for Insurers and ERISA Covered Benefit Plans under the Consolidated Appropriations Act

Jan 6, 2021

The Consolidated Appropriations Act, 2021 (the Act) provides additional funding for mental health and substance abuse services and also provides guidance and imposes additional reporting and compliance obligations on group health plans and health insurance issuers that provide mental health (MH) and/or substance use disorder (SUD) benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act and state insurance laws, already requires parity between medical/surgical and MH/SUD benefits with respect to quantitative (e.g., visit limits) and non-quantitative treatment limitations (NQTL) (e.g., preauthorization and pre-service notification obligations); however, the Act goes further.

GROUP HEALTH PLANS MUST PREPARE A COMPARATIVE ANALYSIS

Under the Act, there are new obligations applicable to group health plans and health insurers in the individual and group markets that provide medical, surgical, and MH and/or SUD benefits and that impose NQTLs on MH and/or SUD benefits. Under the new rules, which amend ERISA, the Code, and the Public Health Security Act, group health plans and issuers are required to formally analyze and document their compliance with the MHPAEA requirements related to NQTLs within 45 days after the date of enactment of the Act. Plans would have to document and make an analysis available, upon request, to the applicable regulator of the plan; i.e., the Secretary of Labor or the Secretary of Health and Human Services (collectively, the Regulators).

Such analysis must contain the following:

i. The specific plan terms or other relevant terms regarding the NQTLs and a description of all MH or SUD and medical or surgical benefits to which each such term applies in each respective benefits classification;

ii. The factors used to determine that the NQTLs will apply to MH or SUD or substance use disorder benefits and medical or surgical benefits;
iii. The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits;
iv. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification; and
v. A disclosure of the specific findings and conclusions reached by the group health plan, including any results of the analyses described in the above, that indicate that the plan is or is not in compliance with this section.

REGULATORY AUDITS

Under the Act, the applicable Regulator is required to request these analyses for plans/policies that involve potential violations or complaints regarding non-compliance and any other instances where the Regulator deems appropriate. The Regulators will be required to request no fewer than 20 of these comparative analyses per year. If the Regulator concludes that the group health plan has not submitted sufficient information for the Regulator to review the comparative analyses, the Regulator will then specify the information the plan must submit to be responsive. If the Regulator concludes the group health plan is not in compliance, within 45 days of that finding, it will require the group health plan to provide the Regulator an action plan that it will implement to bring the plan into compliance, as well as additional comparative analyses. Following the 45-day corrective action period, if the Regulator makes a final determination that the plan is still not in compliance, it will, not later than 7 days after such determination, notify all plan participants that the plan has been determined to not be in compliance with the NQTL requirements of the MHPAEA. Nevertheless, although the Regulators will notify participants regarding the plan's non-compliance, documents or communications produced in connection with the Regulators' recommendations to a group health plan are not subject to disclosure through a Freedom of Information Act request.

No later than 18 months after the date of enactment, the Act also directs the Secretary of Labor to finalize any draft or interim guidance and regulations relating to these mental health parity requirements under the Act, including guidance to clarify the process and timeline for current and potential participants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to plans to file complaints of such plans or issuers being in violation of these requirements, including guidance, by plan type, on the relevant State, regional, or national office with which such complaints should be filed.

Winston Takeaway: *The audit provisions of the Act will likely be onerous for group health plan administrators and insurers. Since no less than 20 such audits will take place annually, and with a 45-day disclosure period, it is advisable to have such analysis readily available soon after the date of enactment in order to be able to timely respond to a Regulator's request. Note that the DOL recently issued an updated Self-Compliance Tool for the MHPAEA, which is a useful tool to assist plan sponsors in assessing compliance with MHPAEA requirements applicable to group health plans.*

HALL OF SHAME

The Act also requires the applicable Regulator to submit to Congress, and make publicly available, a report that contains those group health plans and issuers that are not in compliance with the MHPAEA. Also, the Regulator is required to share information on its findings of compliance and noncompliance

with the states where the group health plan and/or issuer is located.

Winston Takeaway**:** *Group health plans will want to avoid being on this publicly available list, especially since it could open the plan up to potential liability in the form of private litigation and/or insurance premium risk.*

COMPLIANCE PROGRAM GUIDANCE DOCUMENT FROM THE REGULATORS

The Act directs the Regulators and the Secretary of the Treasury to issue a compliance program guidance document to assist health plans and health insurers with respect to their MHPAEA compliance. The Regulators and the Treasury Department are required to update this document every 2 years. This compliance program guidance document is similar to the directive under the 21st Century Cures Act, which in June 2020, directed the Regulators to make a compliance program guidance document and self-compliance tool publicly available to improve compliance with MHPAEA.

This document will include illustrative, de-identified (i.e., does not disclose any protected health information or individually identifiable information) examples of previous findings of MHPAEA compliance and noncompliance. Examples involving non-compliance with NQTLs are required to provide sufficient detail to fully explain the finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving MH and SUD benefits. The goal is that the document will encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. The Regulators' and the Treasury Department's Inspector Generals are also directed to enter into interagency agreements, as well as with state regulatory agencies, to share findings of compliance and non-compliance.

The Regulators and the Treasury Department are also directed to provide clarifying information and illustrative examples of methods that group health plans may use for disclosing information regarding NQTLs. This does not seem to imply new disclosure obligations will be forthcoming, but rather this disclosure guidance will be in accordance with already required disclosure obligations, (e.g., summary plan descriptions and possible claim procedure disclosure materials and sample forms).

CLARIFYING INFORMATION AND ILLUSTRATIVE EXAMPLES FROM THE REGULATORS

The Regulators are instructed to provide "clarifying information and illustrative examples" of methods, processes, strategies, evidentiary standards, and other factors that group health plans may use regarding the development and application of NQTLs. This will provide appropriate types of NQTLs

pertaining to—

- Medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;
- Limitations with respect to prescription drug formulary design; and
- Use of fail-first or step therapy protocols;

and methods of determining—

- Network admission standards (such as credentialing); and
- Factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy.

Winston Takeaway: *The MHPAEA compliance guidance provisions of the Act do not raise any concerns and will likely be quite helpful. However, the Act contains other provisions that could be problematic for plan sponsors as the intent appears to regulate how an insurer and/or a group health plan will administer NQTLs with respect to mental health and substance use disorder benefits.*

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WINSTON & STRAWN LLP

CAA Benefits Alert: 2021 Appropriations Bill Adds New ERISA Disclosure Requirements for Health Plan Brokers and Consultants

Dec 29, 2020

The Consolidated Appropriations Act, 2021 (CAA) includes rules requiring brokers and consultants to disclose compensation that those service providers receive to steer health plan sponsors to certain insurance carriers, benefits administrators, and other vendors. These new comprehensive disclosure rules add a layer of transparency to what has otherwise been a gray area for many employer plan sponsors and are more comprehensive than limited disclosures in effect December 29, 2020, on the Form 5500.

BACKGROUND

ERISA's prohibited transaction rules limit the types of transactions a plan can enter into with "parties in interest," including persons providing services to the plan. The service provider exemption (section 408(b)(2) of ERISA) to the prohibited transaction rules permits a plan to pay reasonable compensation to a party in interest providing necessary services for the plan. Beginning in mid-2012, Department of Labor (DOL) regulations required certain service providers to disclose information about their compensation to a covered retirement plan's fiduciary to enable the fiduciary to determine whether the arrangement is "reasonable." The DOL regulations reserved a section for welfare plan disclosures that were originally proposed by the DOL but not included in the final 2012 rules applicable to retirement plans, and regulators have long indicated that fee disclosure for welfare plans is a priority. The CAA amends the section 408(b)(2) statutory exemption to impose compensation disclosure requirements on health plan service providers that are similar to the requirements applicable to retirement plan service providers.

NEW ERISA DISCLOSURE REQUIREMENTS

The CAA changes the service provider prohibited transaction exemption to add disclosure requirements specific to ERISA group health plans. Once these new rules take effect, no contract or arrangement for brokerage or consulting services is considered reasonable unless certain disclosure requirements are met.

The new rules apply to any service provider that reasonably expects to receive $1,000 (adjusted for inflation) or more in direct or indirect compensation for:

- Brokerage services provided to an ERISA-covered group health plan with respect to the selection of health insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration, stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services, or
- Consulting services related to the development or implementation of plan design, insurance selection (including vision and dental), record- keeping, medical management, benefits administration selection, stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services for an ERISA-covered group health plan.

The $1,000 compensation threshold includes amounts paid to a service provider's affiliate or subcontractor. Note that this threshold is much lower than the $5,000 threshold required by the Form 5500's Schedule C. "Compensation" includes both cash and non-monetary compensation valued at more than $250 (adjusted for inflation) paid, in the aggregate, during the term of the arrangement.

Similar to the disclosure rules applicable to retirement plan service providers, these rules require a covered service provider to disclose, in writing, the following information to the group health plan fiduciary:

- A description of the services to be provided to the covered plan pursuant to the contract or arrangement.
- If applicable, a statement that the service provider (or an affiliate or subcontractor) will provide, or reasonably expects to provide, fiduciary services to the covered plan.
- A description of all direct compensation the service provider (or an affiliate or subcontractor) reasonably expects to receive in connection with the provision of services.
- With respect to indirect compensation, a description of all indirect compensation the service provider (or an affiliate or subcontractor) reasonably expects to receive in connection with the provision of services (including incentives paid to a brokerage firm not solely related to the contract with the covered plan), a description of the arrangement between the payer of the indirect compensation and the recipient service provider; a description of the services for which the indirect compensation is received, and the identity of the payer of the indirect compensation.
- To the extent compensation is paid among a service provider, the service provider's affiliate, or the service provider's subcontractor on a transaction basis (such as commissions or finder's fees), a description of any such arrangement and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or a subcontractor).
- A description of any compensation that the service provider (or an affiliate or subcontractor) reasonably expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.
- A description of the manner in which any direct or indirect compensation will be received by the service provider (or an affiliate or subcontractor).

This information must be disclosed to the responsible plan fiduciary before the contract or arrangement is entered into, extended, or renewed. In addition, the service provider has an affirmative obligation to notify the plan fiduciary of any change to the above required disclosures as soon as practicable, but generally not later than 60 days from the date the service provider is informed of the

change. The service provider must also provide other compensation information requested by the plan fiduciary in order for the plan to comply with its annual Form 5500 reporting and disclosure requirements.

As is the case under the retirement plan disclosure regulations, a health plan fiduciary that meets certain requirements would still satisfy the prohibited transaction exemption if the plan fiduciary relied in good faith on a service provider's disclosures that later turned out to be incomplete or inaccurate. In such a case, the plan fiduciary must take reasonable steps to obtain the missing or incorrect information upon discovery, must inform the DOL, and must consider whether to terminate or continue the arrangement if the service provider fails to comply with a request for information within 90 days.

These disclosure rules apply to any contract executed on or after December 27, 2021 (one year after enactment).

Winston Takeaway: *These new transparency rules potentially apply to any vendor providing brokerage or consulting services to a group health plan funded with plan assets, such as through a trust or separate account or for which employees pay a portion of the cost of coverage (i.e., through premium contributions). Plan sponsors should consider including disclosure language in contracts with any service provider that could be subject to these requirements, and incorporating this disclosure obligation in any requests for proposal. In addition, plan fiduciaries should include review of health plan vendor compensation disclosures as part of their regular monitoring obligations. We expect the DOL will issue further guidance on these new disclosure requirements.*

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CAA Benefits Alert: Flexible Spending Account Relief in the 2021 Consolidated Appropriations Act

Dec 29, 2020

The Consolidated Appropriations Act, 2021 (CAA) includes relief for plan sponsors offering Health Care and/or Dependent Care Flexible Spending Accounts (FSAs). These voluntary rules will benefit participants who have FSA funds left over due to medical care provider and school/daycare closures and remote work arrangements in 2020 as a result of the pandemic.

BACKGROUND

Health Care and/or Dependent Care FSAs may be offered as part of an employer's cafeteria plan. Under the rules governing cafeteria plans, FSAs are generally "use it or lose it" – that is, a participant will forfeit any amounts remaining in the FSA at the end of a plan year.

Prior to the CAA, Internal Revenue Service (IRS) guidance permitted certain FSA plan design options to prevent forfeiture of the amounts participants contributed to these FSAs. Specifically, a Dependent Care FSA could include a grace period of up to two months and 15 days past the end of the plan year for eligible individuals to incur eligible expenses under the FSA, and a Health Care FSA could include either (i) a grace period of up to two months and 15 days past the end of the plan year for eligible individuals to incur eligible expenses under the FSA or (ii) a carryover feature that rolls over a capped amount remaining in the Health Care FSA at the end of the plan year for use during the next plan year. For the 2021 tax year, the maximum carryover amount for the Health Care FSA is $550. A Health Care FSA may not have both a grace period and a carryover feature.

Previous IRS guidance issued in response to the COVID-19 pandemic expanded these rules by allowing plan sponsors to extend through December 31, 2020 an FSA's grace period ending in 2020, and permitted non-calendar year FSAs with plan years ending in 2020 to pay or reimburse eligible expenses incurred through December 31, 2020.

CARRYOVERS PERMITTED FOR PLAN YEARS ENDING IN 2020 AND 2021

For plan years ending in 2020 or 2021, the CAA permits cafeteria plans offering Health Care FSAs and/or Dependent Care FSAs to include a carryover feature. For plan years ending in 2020, the FSA may allow participants to carry over unused amounts remaining in the FSA at the end of the plan year

to the plan year ending in 2021. For plan years ending in 2021, the FSA may allow participants to carry over unused amounts remaining in the FSA at the end of the plan year to the plan year ending in 2022.

The CAA language provides that the permitted carryover would be allowed under rules similar to the rules generally applicable to health FSAs.

Winston Takeaway 1: *While not entirely clear, the CAA language indicates there is no limit on the amount that can be carried over from a Dependent Care FSA or Health Care FSA. Additional IRS guidance addressing the specific rules for CAA carryovers (including any limits) would be helpful. In addition, there is no mention of whether or not this relief also includes Limited-Purpose Health Care FSAs, but we assume it includes all Health Care FSAs, including Limited-Purpose.*

Winston Takeaway 2: *Employees may not contribute to a health savings account ("HSA") while participating in a general purpose Health Care FSA. Employers will sometimes offer a limited purpose or post-deductible HSA to allow participants to take advantage of the carryover feature while still preserving their ability to make HSA contributions. In addition, IRS rules permit participants to waive carryover benefits, but not grace periods. Unless the IRS issues HSA relief guidance, this makes carryover a more flexible option for employees who wish to make HSA contributions.*

GRACE PERIOD EXTENSIONS ALLOWED FOR PLAN YEARS ENDING IN 2020 AND 2021

For plan years ending in 2020 or 2021, the CAA permits cafeteria plans offering Health Care FSAs and/or Dependent Care FSAs with a grace period to extend the grace period to 12 months after the end of the plan year. This increases the maximum grace period length from two months and 15 days to 12 months.

In addition, the CAA permits FSAs to reimburse terminated participants for expenses incurred through the end of the plan year in which the participant ceased participation in the FSA, provided the participant terminated participation in the calendar year 2020 or 2021. (Please note that many Dependent Care FSAs already permit reimbursement for dependent care expenses incurred through the end of the plan year in which the participant ceased participation.) For this purpose, the end of the plan year in which the participant ceased participation in the FSA includes any grace period, including a grace period extended pursuant to the CAA.

Winston Takeaway 1: *Participants may not contribute to an HSA while General Purpose Health Care FSA funds are available to the participant during a grace period. Typically, participants with Health Care FSA funds left at the end of a plan year are not permitted to make HSA contributions until the end of the grace period. The CAA does not contain relief for participants who would be entitled to this grace period extension for General Purpose Health Care FSA funds during the prior plan year but who elected coverage under a HDHP with HSA for the following plan year. Unlike with carryovers, participants with a remaining balance cannot waive or decline coverage during the grace period. Further IRS relief on this issue would be welcomed.*

Winston Takeaway 2: *Plans contemplating offering terminated participants the ability to be reimbursed for expenses incurred through the end of the plan year in which participants terminate participation should assess the administrative burden of communicating to such participants and administering claims, particularly where the plan is also opting to extend the grace period to 12 months after the end of the plan year.*

Winston Takeaway 3: *The grace period and carryover relief provided by the CAA are optional. Plan sponsors may elect to adopt these extensions only for all FSA plans, for Dependent Care FSAs but not Health Care FSAs, or vice versa. In addition, plan sponsors may elect to apply the extension to the 2020 plan year but not the 2021 plan year.*

DEPENDENT CARE FSA EXCEPTION FOR DEPENDENTS WHO AGE OUT DURING PANDEMIC

The CAA increases the maximum age of a dependent for purposes of incurring eligible Dependent Care FSA expenses to 14, from 13, for certain Dependent Care FSA participants. This extension applies to a Dependent Care FSA participant who has one or more dependents who attain age 13 during the last plan year whose enrollment period ended on or before January 31, 2020 (the "2020 plan year"). For calendar year plans, the rule applies to a Dependent Care FSA participant with a dependent who turned 13 years old during calendar year 2020. In addition, this extension applies during the subsequent plan year if such a participant has unused amounts in the Dependent Care FSA at the end of the 2020 plan year (determined as of the FSA's claims submission deadline for the 2020 plan year) after applying the extension.

Winston Takeaway: *This provision temporarily changes the limiting age for dependent care assistance under Section 21(b)(1)(A) of the Internal Revenue Code. This change would apply automatically to Dependent Care FSAs unless the plan specifically included an age 13 limitation (rather than a reference to the relevant Code section).*

PERMITTED FSA ELECTION CHANGES FOR PLAN YEARS ENDING IN 2021

Under the CAA, FSAs may permit a participant to modify his or her elected FSA contribution amount on a prospective basis (subject to the IRS maximum dollar limitations on FSA contributions), for any reason. The participant need not have experienced a change in status or any other event to make this election change.

Winston Takeaway: *Plan sponsors adopting this change should clearly communicate the terms under which the plan will allow these changes to be made. While some plans may want to allow these changes at any time, others may want to limit the election change period to a specific time frame (similar to a mini open enrollment) to lessen the administrative burden. Also, it would be best to check with an FSA third-party administrator to see what and how that entity can administer this option.*

PLAN AMENDMENTS

Plans adopting any of the plan design changes permitted by the CAA must be amended by the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective. For example, a plan adopting the carryover for the Dependent Care FSA plan year ending December 31, 2021 must adopt the related plan amendment by December 31, 2022. In addition, the plan must be operated in accordance with the terms of the amendment from the date the amendment is effective, even if prior to the actual amendment adoption date.

Winston Takeaway: *The plan amendment provisions do not appear to alter the general rules for adding a new grace period feature or replacing a grace period with a carryover. Therefore, for the 2020 plan year, the permitted grace period extension would only apply to those FSAs that already have a grace period feature. Adoption of a grace period must be made by the end of the plan year to*

which it applies, which does not leave much time for calendar year plans that do not already have a grace period to adopt one for the 2020 plan year. Additional amendment relief to allow plan sponsors to take full advantage of the grace period extension would be welcome.

CONCLUSION

Plan sponsors should assess whether they want to take advantage of the relief offered to FSAs under the CAA, and discuss the implementation and communication of these changes with their third-party administrators. It is likely many participants have funds left over in their Health Care and Dependent Care FSAs due to medical care provider and school/daycare closures and remote work arrangements in 2020 as a result of the pandemic, and plan sponsors should determine whether utilizing the relief under the CAA can help avoid forfeiture of these amounts. In addition, participants have already elected amounts to contribute to FSAs for the 2021 plan year and may need to adjust goal amounts to take into account these new carryover and grace period features.

Time is particularly of the essence for sponsors of calendar year FSAs looking to make any of these changes for the 2021 plan year. Any adopted changes should be promptly and clearly communicated to participants.

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