WorkSmarts Half-Day Seminar

Employee Benefits Update: Health Plan Changes on the Horizon

Greg Ash

SpencerFane

Agenda

- Background – Transparency as the Regulatory Theme for Health Plans
- Transparency in Coverage Regulations and Effective Dates
- Consolidated Appropriations Act and Effective Dates
  - “No Surprises Act” Requirements
  - CAA Transparency Requirements
- COVID-19 Vaccine Surcharge Issues
- WorkSmart Tips

Transparency – The Overarching Theme

- Need for transparency has driven health care reform efforts
  - Transparency for participants (surprise billing, price transparency, etc.)
  - Transparency among providers and plans/insurers (non-network rates, gag clauses)
  - Transparency among employers and consultants (fee disclosures)
  - Transparency among plans and enforcement agencies (Rx benefit costs, equity of plan design)
- The result:
  - Affordable Care Act price transparency regulations
  - Consolidated Appropriations Act, 2021

Doubling Down on Health Plan Transparency

- **Affordable Care Act – Transparency in Coverage (“TiC”) Rules**
  - Regulations issued November 2020
  - Requires public disclosure of in-network rates and historical non-network allowed amounts via public website
  - Generally effective late 2022 and 2023
- **Consolidated Appropriations Act, 2021 (“CAA”)**
  - Signed December 27, 2020
  - “No Surprises Act” and transparency requirements for group health plans
  - Generally effective for plan years beginning on/after January 1, 2022
  - Initial regulations issued July 2021
- TiC and CAA transparency requirements often overlap, creating confusion about scope and effective dates

Implementation of Some Key Provisions Delayed

- August 20, 2021, FAQs issued by DOL, HHS, and Treasury
- Recognized imminent effective dates and need for additional time to comply
- Additional guidance and coordination between overlapping TiC and CAA provisions forthcoming
- For certain rules that were not delayed, employers held to a “good faith” standard

Ramifications for Employers

- Significant changes beginning in 2021 for:
  - Plan design
  - Information reporting
  - Participant notices and communication
- Insurers (for employers with fully insured plans) and third-party administrators (for those with self-funded plans) will primarily be responsible for implementing these changes

Beware the Iceberg

- Smooth sailing for employers?
  - Heavy burden of TiC and CAA compliance will fall on insurers and TPAs
  - ***But***, penalty for noncompliance falls mainly on plan sponsors and administrators (*i.e.*, employers)
    - Penalties for noncompliance up to $10,000 (CAA)
    - ERISA remedies also available
- ***Bottom line***: Employers should obtain written assurances and strong indemnification promises from TPAs, insurers, and consultants
- Employers need to understand what's beneath the surface (the minutiae of the rules) to protect themselves

Transparency in Coverage Regulations

TiC – Machine-Readable Files

- TiC regulations require *nongrandfathered* group health plans to disclose:
  - In-network provider rates for covered services;
  - Historical non-network allowed amounts for covered services; and
  - Negotiated rates and historical net prices for covered prescription drugs
- Must be posted on public website in machine-readable files
- Updated monthly
- Original effective date of regulations (issued prior to CAA) was January 1, 2022
- Enforcement deferred to July 1, 2022 by Department FAQs
- Rx reporting delayed indefinitely due to overlap with similar CAA reporting requirements

TiC and CAA – Price Comparison Tools

- Nongrandfathered group health plans must make price comparison tools available through internet or in paper form (on request)
  - TiC requirement applicable for plan years beginning on/after January 1, 2023 for 500 items and services, and more in subsequent years
- CAA also requires both nongrandfathered *and* grandfathered plans to offer price comparison guidance by phone and through internet
  - Original effective date January 1, 2022
- FAQs delayed CAA price comparison tool effective date to January 1, 2023
  - Future guidance will reconcile inconsistencies between TiC and CAA rules

“No Surprises Act” and Transparency Requirements

CAA – “No Surprises Act”

- Intended to protect patients from unexpected bills in situations where they are most vulnerable
- Imposes limits on cost-sharing and other restrictions plans and insurers may impose on non-network providers
- Significant new notice obligations for plans and insurers
- Applies to grandfathered and nongrandfathered, fully insured and self-funded plans
  - Excludes “excepted benefits” and account-based plans (*e.g.*, HRAs)
- Generally effective for plan years beginning on/after January 1, 2022
  - *Not* delayed by FAQs

“No Surprises Act” Overview

- **Restricts “balance billing” in three circumstances”**
  - Emergency services by non-network providers
  - Non-emergency services by non-network providers at in-network facilitates (*e.g.*, non-network anesthesiologist working at in-network hospital)
  - Non-network air ambulance services (if plan covers in-network air ambulance)
- **No Surprises Act:**
  - Prohibits non-network providers from balance billing participants
  - Requires plans to count cost-sharing payments for such non-network services towards any applicable in-network deductible or OOP maximum
  - Limits participants to in-network cost-sharing
  - Describes what plan is required to pay non-network provider, and establishes dispute resolution process
  - Requires plans to notify participants (in EOB) of limits on non-network providers’ rights to payment

Other CAA Transparency Requirements

- **Advance EOBs**
  - When plan participant schedules services, providers must inquire if individual is covered by group health plan, and provide plan a good faith estimate of expected charges
  - Plan is then required (on request) to send participant an advance explanation of benefits that includes specific information
  - Tight time frames for response
  - Original effective date = January 1, 2022
  - Department FAQs deferred enforcement of rule until regulations are issued

Other CAA Transparency Requirements

- **Health Plan ID Cards**
  - Must include additional information
  - Deductibles (in- and out-of-network amounts)
  - Out of pocket maximum
  - Consumer assistance information
  - Effective January 1, 2022
  - FAQs indicate no regulatory guidance expected, and plans must use a good faith, reasonable interpretation of the law in the interim

Other CAA Transparency Requirements

- **Continuity of Care**
  - Plans and issuers must notify “continuing care patients” of changes in network status of treating providers (*e.g.*, if provider’s contract is terminating)
  - Must give participant opportunity to notify plan or issuer of need for transitional care
  - Must permit patient to elect to continue benefits under same terms and conditions (*i.e.*, as in-network) for 90 days
  - No regulations expected; plans must implement using good faith standard
- **Updated Provider Directories**
  - Plans must maintain up-to-date network provider directories and verify provider information at least every 90 days
  - Inaccurate provider information limits participant’s cost-sharing obligation to in-network amounts
  - No regulations expected; plans must implement using good faith standard

Other CAA Transparency Requirements

- **Pharmacy Benefit Cost Reporting**
  - New requirement to annually report detailed information on pharmacy benefits, drug costs, drug rebates, and participant costs
  - First report was to be due December 27, 2021, and each June 1 thereafter
  - FAQs defer enforcement of these requirements until further guidance is issued
  - Departments “strongly encourage” plans to be able to begin reporting by December 27, 2022
- **Prohibition on “Gag” Clauses**
  - Plans and insurers prohibited from entering into contracts that directly or indirectly restrict disclosure of provider-specific cost and quality information
  - Contracts may not restrict plans/issuers from sharing such information with HIPAA business associates or plan participants
  - Plans and issuers must submit annual attestation of compliance to Departments
  - Clauses are common in ASO, PPA, and PBM agreements (as “proprietary” information about provider)
  - Effective immediately
  - No regulations expected; plans must implement using good faith standard; guidance on annual attestation to government expected for 2022

Other CAA Transparency Requirements

- **Compensation Disclosures for Consultants** (ERISA § 408(b)(2))
  - CAA expands § 408(b)(2) disclosure requirements to ERISA-covered group health plans
  - "Covered service providers" to "covered plans" must disclose to plan fiduciaries a description of:
    - Services to be performed
    - Direct and indirect compensation reasonably expected to be received
  - Failure to provide disclosures creates nonexempt prohibited transaction
  - Effective for contracts executed or renewed after December 31, 2021
  - No delay in implementation

Other CAA Transparency Requirements

- **Mental Health & Substance Use Disorder Analysis**
  - Plans and issuers must be able to provide, if requested by DOL, HHS, or state insurance regulator, detailed written analysis of compliance with MHPAEA's nonquantitative treatment limitations ("NQTLs")
    - NQTLs = restrictions on coverage that are not expressed numerically
    - Ex.: medical necessity standards, experimental treatment exclusions, Rx formulary design
  - Effective Feb. 10, 2021 (*i.e.*, **now**)
  - No delayed implementation by FAQs
  - DOL actively enforcing requirement (*e.g.*, in plan audits)
  - Very little coordination with, cooperation by, TPAs, PBMs, etc.

Delayed Provisions

Provision	Effective Date
Transparency in Coverage (ACA) — Machine-Readable Files for In-Network Rates and Out-of-Network Allowed Amounts and Billed Charges	Delayed ○ For plan years beginning on and after January 1, 2022, deferred enforcement until July 1, 2022
Transparency in Coverage (ACA) — Machine-Readable Files for Prescription Drug Pricing	Delayed until unknown date
Transparency in Coverage — Price Comparison Guidance (CAA)	Delayed ○ Effective for plan years beginning on and after January 1, 2023
Advanced EOBs (CAA)	Delayed until regulations issued
Reporting on Pharmacy and Drug Costs (CAA)	Delayed until regulations or further guidance issued ○ First reports likely due in December of 2022

No Delay

Provision	Effective Date
Transparency in Coverage — Price Comparison Tool (ACA)	No delay ○ For 500 specified items and services in the regulations, effective for plan years beginning on and after January 1, 2023 ○ For all covered items and services, for plan years beginning on and after January 1, 2024
Insurance Identification Card (CAA)	No delay ○ Effective for plan years that begin on and after January 1, 2022 ○ Subject to a good faith, reasonable interpretation of the statute
Prohibition on Gag Clauses (CAA)	No delay ○ Already effective as of December 27, 2020 ○ Subject to a good faith, reasonable interpretation of the statute until regulations issued
Accuracy of the Provider Directory (CAA)	No delay ○ Effective for plan years that begin on and after January 1, 2022 ○ Subject to a good faith, reasonable interpretation of the statute until regulations issued
Continuity of Care (CAA)	No delay ○ Effective for plan years that begin on and after January 1, 2022 ○ Subject to a good faith, reasonable interpretation of the statute until regulations issued

COVID Vaccine Surcharge

Another Tool for Employers?

- **Objective**: Encourage COVID-19 vaccination by imposing surcharge on health plan contributions or other costs for unvaccinated employees
  - Less drastic alternative to vaccine mandates as a condition of employment
  - Cost of coverage for unvaccinated employees is increased by surcharge
- **Delta Airlines**:
  - Effective November 1, 2021, unvaccinated Delta employees pay $200/month surcharge/penalty for health plan coverage
  - Intended to help offset $50,000 per claim (on average) cost of COVID-related hospitalization
  - Vaccination rates increased five-fold after announcement of surcharge
- Necessary after Biden's *Path Out of the Pandemic* vaccine mandate?

Regulatory Hoops

- HIPAA Nondiscrimination Rules
- ADA Prohibition on Disability-Based Discrimination
- ACA “Affordability” Analysis
- Title VII
- GINA
- ERISA

HIPAA Nondiscrimination Rule

- ***General Rule:*** Group health plan or issuer can't require "similarly situated individuals" to satisfy different deductible, co-payment, or other cost-sharing requirements based on a "health factor"
  - Vaccinated status is likely a "health factor"
- ***Wellness Program Exception:*** A plan **can** offer premium discounts (or other modifications of its cost-sharing rules) if the reward/penalty is based on participation in a program of health promotion or disease prevention (a "wellness program")
  - ***Participation-Only Programs***
  - ***Health-Contingent Programs***
    - *Activity-Only*
    - *Outcomes-Based*

Participation-Only Programs

- No reward is offered, or reward is available regardless of whether individual satisfies a standard related to a health factor
  - Examples:
    - Completion of a health risk assessment
    - Participation in educational programs
    - Attend a health fair
    - Join a fitness club
    - Smoking cessation (regardless of whether individual quits smoking)
  - **Requirements**:
    - Must be made available to all similarly situated individuals
    - No limit on financial incentives/surcharge
      - But incentive/surcharge still taken into account for ACA “affordability” determination
    - No requirement to offer reasonable alternative standard

Health-Contingent Programs

- Require an individual to satisfy a standard related to a health factor in order to obtain a reward, or require an individual to do more than a similarly situated individual based on a health factor in order to obtain the same reward
  - ***Activity-Only*** – Reward based on *activity* that is related to a health factor
    - Examples:
      - Exercise program (even walking)
      - Diet program
  - ***Outcome-Based*** – Reward based on a *specific result* related to a health factor
    - Examples:
      - Losing or maintaining a certain weight or BMI
      - Cholesterol level
      - Non-smoking status

Health-Contingent Programs

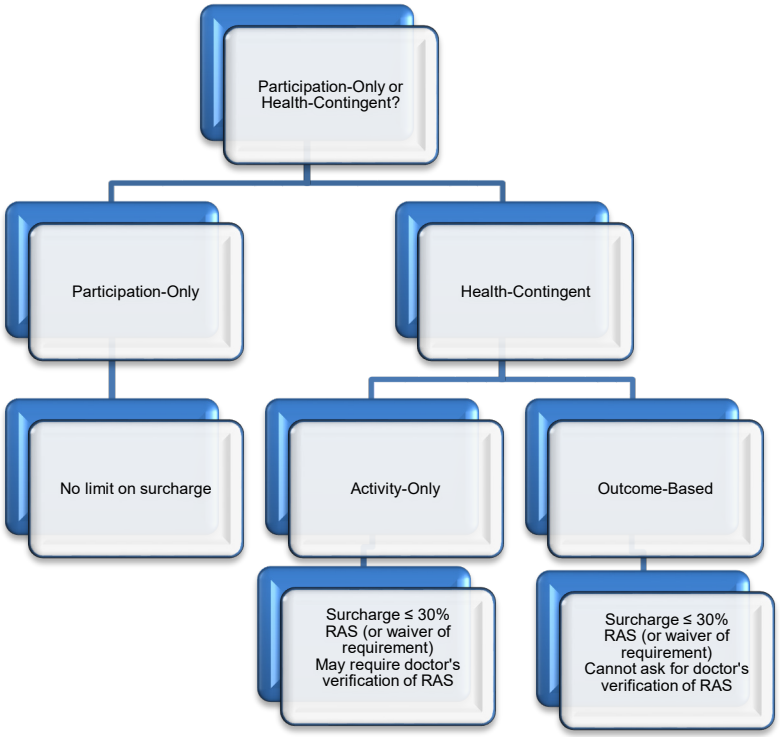
- **Requirements:**
  - Limited surcharge/reward
    - Generally 30% of cost of employee-only coverage
    - 50% for tobacco-related incentives
      - *But ACA "affordability" requirement may further limit surcharge*
  - Available at least once/year
  - Reasonably designed to promote health or prevent disease
  - Offer "reasonable alternative standard" to those for whom it is medically inadvisable or unreasonably difficult to satisfy the incentive requirement
    - *Activity-Only* – may require doctor's verification
    - *Outcome-Based* – impermissible to require doctor's verification
  - Notice of availability of RAS

Proceed With Caution

- Gray Area
  - Little EEOC guidance after withdrawal of final regulations in January
  - Participation-only or health-contingent?
  - Effect on ACA “affordability” analysis may limit size of surcharge
  - Title VII accommodation for religious objection to vaccine
  - Potential for litigation

Vaccine Surcharge Decision Matrix

Evaluate effect on ACA affordability



Title VII accommodation for religious objection

KC 17828142.1

WorkSmarts

Top Tips

Update Plan Documents and SPDs for CAA Changes in Advance of Open Enrollment

- Surprise billing standards under “No Surprises Act”
- Emergency services and OON claims
- Balance billing protection
- Continuing care protection
- Provider directories

WorkSmarts

Top Tips

Update Agreements with Plan Vendors

- Review and update ASO agreements
  - Allocation of responsibilities for CAA and TiC compliance to TPA/ASO provider
  - Review and revise for prohibited “gag” clauses
  - Review adequacy of indemnification language

WorkSmarts

Top Tips

Coordinate with Consultants

- Request MHPAEA NQTL analysis
  - “Fiduciary protection” letter
  - Pay particular attention to “carve-out” pharmacy or MH/SUD providers (who are unlikely to coordinate with M/S vendors to ensure parity)
- Request ERISA § 408(b)(2) disclosures

WorkSmarts

Top Tips

Consider COVID Vaccine Surcharge Carefully

- Evaluate existing wellness program incentive awards and ACA affordability restrictions to determine maximum surcharge
  - Consider higher deductible or co-payments for unvaccinated participants, rather than higher premium
- Update wellness program materials to include required information about reasonable alternative standards, etc.
- Determine how long you will give participants to obtain vaccines, and whether/how surcharge will be refunded if vaccine obtained after plan year commences
- If implemented mid-year, consider change-in-status rules for cost increases
- Consider any collective bargaining implications
- Evaluate approach to reasonable alternative standards for those who refuse vaccine

Thank You

Greg Ash

Partner | Overland Park, KS

913.327.5115 | gash@spencerfane.com