# CONSOLIDATED APPROPRIATIONS ACT: IMPACT ON HEALTH AND WELFARE PLANS

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# Presenters

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# Agenda

- Temporary Special Rules for Health and Dependent Care Flexible Spending Accounts (FSAs)
- Transparency Provisions
- Surprise Medical Billing (“No Surprises Act”)

# Temporary Special Rules for Health and Dependent Care FSAs

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# Flexible Spending Accounts

- Health Care Flexible Spending Account (HCFSA)
  - Permit carryover of unlimited amounts of unused HCFSA dollars from the plan year ending in 2020 into the plan year ending in 2021
  - Permit carryover of unlimited amounts of unused HCFSA dollars from the plan year ending in 2021 into the plan year ending in 2022
    - Be aware of any individuals who migrate to HDHP/HSA
  - Permit extension of an existing grace period for the plan year ending in 2020 (March 15, 2021) through December 31, 2021
  - Permit extension of an existing grace period for the plan year ending in 2021 (March 15, 2022) through December 31, 2022
    - More significant HDHP/HSA concerns

# Flexible Spending Accounts

- Dependent Care Flexible Spending Account (DCFSA)
  - Permit the carryover of unlimited unused DCFSA dollars from the plan year ending in 2020 to the plan year ending in 2021
  - Permit the carryover of unlimited unused DCFSA dollars from the plan year ending in 2021 to the plan year ending in 2022
    - DCFSAs have not historically been permitted to provide carryovers
  - Permit the extension of an existing grace period for the plan year ending in 2020 (March 15, 2021) through December 31, 2021
  - Permit the extension of an existing grace period for the plan year ending in 2021 (March 14, 2022) through December 31, 2022

# Additional Permissible Changes

- Permit an employee who ceases participation in an HCFSA to continue to receive reimbursements from unused benefits or contributions through the end of the plan year in which participation ceases (including any grace periods)
  - Provides an opportunity for employees to continue incurring claims and spending down any unused balances
  - Applies to 2020 and 2021 calendar years
- Extend the eligible dependent age from under age 13 to under age 14
  - Must have been enrolled in the plan before January 31, 2020
  - Changes the statutory language
  - Review plan document/summary plan description

# Flexible Spending Accounts

- Permit prospective participant election change opportunities under an HCFSA or DCFSA
  - Only for plan years ending in 2021

- Plans have to be amended prior to December 31 of the plan year in which the change is effective.

# Transparency Provisions

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# Mental Health Parity Analysis

- Mental Health Parity Non-Quantitative Treatment Limitations (NQTLs) Analysis
  - Group health plans are now required to conduct comparative analyses of the NQTLs used for medical/surgical benefits as compared to mental health and substance use disorder benefits
    - Some examples of NQTLs: medical management standards, formulary design for prescription drugs, fail-first policies, or step therapy protocols
  - Must also be able to provide, if requested by the DOL, HHS, or state insurance regulator (if applicable), a detailed written analysis of such compliance with the Mental Health Parity Act
    - Requests may start to be made by regulators as soon as February 10, 2021 (45 days after enactment of CAA)
      - While it's possible that requests may start to come in, it seems unlikely without additional guidance
      - Plan sponsors should start to prepare if they are not already conducting this analysis
        - Your service providers are likely to assist with this analysis

# Mental Health Parity Analysis

- Analysis should include:
  - Factors used to determine that NQTLs will apply to mental health or substance use disorder benefits and medical/surgical benefits;
  - Evidentiary standards used for the factors identified; and
  - Results of such comparative analyses
- Tri-Agencies are required to request comparative analyses from at least 20 plans per year that involve potential violations of the Mental Health Parity Act
  - If found noncompliant, plans have 45 days to correct each compliance issue
  - If a final determination of noncompliance is made, plans are required to notify enrollees of noncompliance within seven days
- Tri-Agencies are required to issue guidance within 18 months with at least a 60-day comment period

# Mental Health Parity Analysis

- What to do now
  - Talk to TPA/insurance carriers
  - Conduct a self-audit of compliance
    - DOL and HHS have several tools to help demonstrate NQTL compliance and identify weaknesses in compliance
      - DOL's Mental Health Parity Self-Compliance Tool **https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf**
      - HHS Warning Signs Regarding NQTLs **https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/mhapeachecklistwarningsigns.pdf**

# Gag Clauses

- Prohibition on Gag Clauses
  - Gag Clauses are now prohibited
  - Group health plans cannot enter into any services agreements that directly or indirectly restrict the group health plans from disclosing provider-specific costs or quality of care information, or electronically accessing de-identified claims data
  - Likely effective upon enactment of CAA, but not entirely clear
  - Review existing service agreements and future agreements for compliance

# Disclosure of Compensation

- Broker Disclosure of Compensation
  - Health benefit brokers and consultants will now be required to disclose to plan sponsors a description of the following:
    - The services to be performed; and
    - Their reasonably expected direct and indirect compensation for referral of brokerage or consulting services
  - Must be provided up front at the time of contracting
  - This does not apply to insurance providers or pharmacy benefit managers
  - Only applies if direct or indirect compensation will be more than $1,000
  - Effective 12/27/21 (one year after enactment of CAA)

# Reporting of Benefits & Costs

- Required Annual Reporting on Pharmacy Benefits and Drug Costs
  - Group health plans are now required to annually report on plan medical costs, prescription drug spending, premiums, and any manufacturer rebates received by the plans to the Tri-Agencies
  - First reporting is due 12/27/21 (one year after enactment of CAA)
    - Each subsequent report would be due by June 1 of each year
  - Most plan sponsors will have their vendors do this reporting

# Surprise Medical Billing ("No Surprises Act")

# "No Surprises Act"

- Prohibits surprise medical billing for all out-of-network (OON) emergency services, air ambulance services, and certain OON services provided at in-network facilities
- Applies to group health plans and issuers, including self-insured group health plans and grandfathered plans
- Amends the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (Code)
  - Additional conforming PHSA provisions for providers
  - Special related amendments under the Code related to HDHP/HSAs
- Generally effective January 1, 2022
  - Future regulations will provide many details

# What Is "Surprise Medical Billing"?

- Not defined
- Intended to include:
  - Balance billed amounts (i.e., the difference between the actual amount billed by an OON provider/facility and the allowed amount the plan/issuer will pay)
  - OON cost-sharing (e.g., copayments, coinsurance)
  - OON deductibles and out-of-pocket maximums
  - Additional fees and expenses charged by the OON provider/facility

# Coverage of Emergency Services

- Replaces Affordable Care Act provisions effective January 1, 2022
- Requires plans that cover "emergency services" do so:
  - Without the need for any prior authorization determination or limitation on coverage that is more restrictive than what is applied in-network
  - Without imposing any cost-sharing on OON emergency services that is greater than the in-network cost-sharing amounts
  - Any cost-sharing payments for OON emergency services must be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage
- Balance billing is not permitted

# What Is an "Emergency Service"?

- Much broader than the Affordable Care Act definition
  - Includes independent freestanding emergency departments
  - Includes covered items and services that are furnished by an OON provider or OON emergency facility:
    - AFTER the participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay; and
    - regardless of the department of the hospital in which such items or services are furnished

# Air Ambulance Services

- To the extent that air ambulance services would have been covered under the plan or coverage if provided in-network
  - OON air ambulance services must be covered without imposing any cost-sharing on OON air ambulance services that is greater than the in-network cost-sharing amounts
  - Any cost-sharing payments for OON air ambulance services must be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage
- Balance billing not permitted
- Ground ambulances EXCLUDED
- Additional reporting requirements for both air ambulance providers and plans/issuers

# Nonemergency Services Provided by OON Providers at In-Network Facilities

- For OON providers performing covered nonemergency services at in-network facilities
  - The plan or coverage may not impose any cost-sharing on the items or services that is greater than the in-network cost-sharing amounts
  - Any cost-sharing payments for the OON emergency services must be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage
- Balance billing generally not permitted
- **Exception for participants who provide informed consent**

# Notice and Consent Criteria

- 72-hour advance written notice that:
  - Notifies the participant that the provider/facility is OON
  - Provides a good-faith estimate of the OON provider/facility's charges
  - Includes prior authorization and case management requirements
  - Clearly states that the consent to receive such items and services from the OON provider/facility is optional and the participant may seek alternative care
    - OON facilities must also furnish a list of participating providers at the facility that can furnish the item or service
- For participants who make appointments within 72 hours, notice and consent can be provided on the date the appointment is made
- Notice must be made available in the 15 most common languages in the geographic area

# Notice and Consent

- Narrow exception
  - Participant must be in a condition to provide informed consent
  - Cannot be used for items or services furnished as a result of an unforeseen, urgent medical need that arises contemporaneously
  - Cannot be used for ancillary services
- **OON providers that give proper notice and receive consent cannot later submit to the Independent Dispute Resolution (IDR) process**

# Pre-IDR: Open Negotiation

- Plan/issuer must either deny the claim or determine that the claim is covered and make an "initial payment" directly to the OON provider/facility within 30 days after receiving the bill
- Once the provider/facility receives the payment or the denial, the provider/facility or plan/issuer has 30 days to initiate an open negotiation for the parties to agree to a payment amount (including any cost-sharing)
- 30-day open negotiation period
- If the open negotiation fails, the provider/facility or plan/issuer has four days to initiate the IDR by notifying the other party and the Secretary*
  - No minimum rate required

# IDR Elements

- What we know:
  - "Baseball style" arbitration
  - Multiple cases may be submitted together
  - 90-day "cooling off period"
- Additional Tri-Agency rulemaking on:
  - The IDR process (by December 27, 2021)
  - A process to certify (or recertify) "IDR entities" (i.e., arbitrators)

# IDR Entities

- A certified IDR entity:
  - Must have sufficient medical, legal, and other expertise and sufficient staffing to make timely determinations
  - Meets appropriate indicators of fiscal integrity
  - Maintains the confidentiality of individually identifiable health information
  - Cannot be a group health plan, issuer, provider, or facility; an affiliate or subsidiary of such entities; or an affiliate or subsidiary of a professional or trade association of such entities
- IDR entity certification lasts for five years (but can be revoked if there is a pattern or practice of noncompliance)
- Plans and issuers may petition for a denial or revocation of an IDR entity's certification

# IDR Process

- Plan/issuer and provider/facility will jointly select (within three business days) a certified IDR entity. If the parties do not make such selection, the Secretary may (within six business days) select an IDR entity.

- The IDR entity is prohibited from considering usual and customary charges, the provider/facility billed charges, or Medicare, Medicaid, CHIP, or TRICARE rates

- The IDR entity is required to consider the prevailing in-network negotiated payment rates, requested information, and other relevant information

# IDR Determinations

- The IDR entity's determination is binding upon the parties and is not subject to judicial review
- The plan/issuer is required to pay the provider/facility within 30 days of the determination
- The party whose offer is not chosen is responsible for paying all fees charged
- If the parties reach a settlement prior to the IDR entity's determination, each party shall pay half of the IDR fees
  - Parties may agree to some other fee payment structure

# IDR Disclosures

- Beginning in 2022 and quarterly thereafter, the Secretaries are required to make the following information about the IDR process on a public website:
  - The number of notifications it receives from plans, issuers, providers, and facilities that initiate IDR*
  - The size of the provider practices and the size of the facilities initiating the IDR
  - The number of determinations made by IDR entities
  - Information about the underlying item or service
  - The number of times the payment amount determined or agreed to exceeds the "qualifying payment amount"
  - The amount spent by the Secretary to carry out the IDR process
  - The total administrative fees the parties paid to the Secretary
  - The total amount of compensation paid to certified IDR entities
- Confidential information is excluded

# Patient Protections

- Replaces the Affordable Care Act "choice of health care professional" provisions:
  - Designation of primary care provider (PCP)
  - Pediatrician PCP designation (for children)
  - Access to OB/GYN care
    - OB/GYNs treated as PCPs
    - No prior authorizations or referrals to access OB/GYNs
- Provisions largely unchanged, but will apply to grandfathered plans
- Effective January 1, 2022

# Additional Consumer Protections

- Disclosure requirements for group health plans and health insurance issuers:
  - Include in-network and OON deductible amounts and maximum out-of-pocket costs on insurance ID cards
  - Provide "Advanced Explanation of Benefits" that includes:
    - Good-faith estimates of the costs of services the participant is likely to receive; and
    - Associated disclaimers
  - Offer price comparison guidance via telephone and an online cost comparison tool
  - Provide participants with up-to-date provider directories
    - Participants who rely on incorrect information that they receive will only be liable for in-network cost-sharing amounts

# Additional Consumer Protections

- Directs the Tri-Agencies to issue proposed regulations under the Affordable Care Act's "Provider Nondiscrimination" protections
- Extends the Affordable Care Act's external review process to adverse benefit determinations under the surprising billing provisions
- Requires that certain participants be able to receive up to 90 days of continued coverage at in-network cost-sharing rates when their providers move out of network
- Establishes a grant program to create and improve "State All Payer Claims Databases"
  - Voluntary reporting for self-insured group health plans only

# QUESTIONS?

# Coronavirus COVID-19 Resources

We have formed a multidisciplinary **Coronavirus/COVID-19 Task Force** to help guide clients through the broad scope of legal issues brought on by this public health challenge.

To help keep you on top of developments as they unfold, we also have launched a resource page on our website at **www.morganlewis.com/topics/coronavirus-covid-19**

If you would like to receive a daily digest of all new updates to the page, please visit the resource page to **subscribe** using the purple "Stay Up to Date" button.

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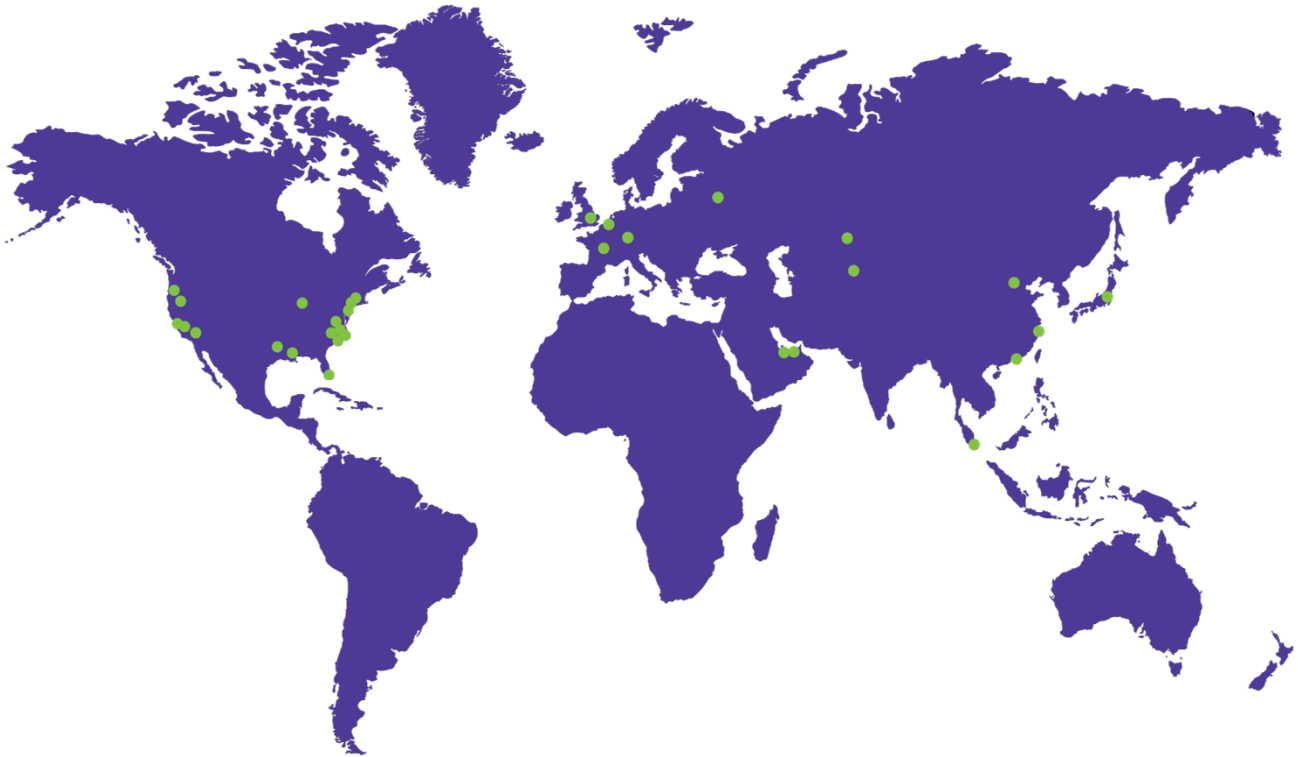

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# THANK YOU