HUNTON
ANDREWS KURTH

Unraveling the Web of Surprise Billing and Transparency Requirements: What Group Health Plan Sponsors Need to Know Now

Presentation for:
Employee Benefits Academy
March 24, 2022

Presentation by:
Jessica Agostinho, Partner
Michelle Lewis, Associate

Jessica Agostinho

HUNTON
ANDREWS KURTH

Partner
Email: jagostinho@HuntonAK.com
Phone: 202-419-2110

2200 Pennsylvania Avenue NW
Washington, DC 20037

Jessica helps clients navigate the complex and evolving area of employee benefits law, including health care reform, tax-qualified retirement plans and executive compensation.

Jessica works with clients on a broad array of employee benefits matters, advising on compliance with ERISA, the Internal Revenue Code, the Affordable Care Act, HIPAA and COBRA. She regularly assists clients with correcting plan errors under the IRS' Employee Plans Compliance Resolution System (EPCRS). She also frequently works with clients on negotiating employee benefit vendor contracts and HIPAA business associate agreements for employee benefit plans.

In corporate transactions, Jessica negotiates employee benefits representations and covenants, conducts due diligence review of employee benefit plan documentation, and advises clients on executive compensation issues arising under Section 409A and Section 280G.

Michelle Lewis

HUNTON
ANDREWS KURTH

Michelle concentrates her practice in the areas of health and welfare plans, qualified retirement plans, and executive deferred compensation plans.

She delivers insightful and practical advice to clients in addressing a broad spectrum of employee benefit issues, including drafting plan documents, preparing IRS submissions, resolving ERISA and Internal Revenue Code compliance issues, advising on benefit claims and appeals, addressing various litigation issues, and negotiating employee benefit vendor contracts and HIPAA business associate agreements.

Associate
Email: mlewis@HuntonAK.com
Phone: 202-955-1859

2200 Pennsylvania Avenue NW
Washington, DC 20037

Upcoming 2022 Webinars

HUNTON ANDREWS KURTH

- **Upcoming 2022 webinars**:
  - **May 26**: Investment Policy Basics and Considerations for 401(k) plans
  - **July 28**: Phased Retirement and Similar Employment Contributions
  - **September 22**: Cafeteria Plan Non-Discrimination Testing
  - **November 17:** End of Year Benefits "To-Do" List
  - Sign up here: **Employee Benefits Academy Webinar Series - Subscribe**

Introduction – Topics Covered

HUNTON
ANDREWS KURTH

- Health Care and Prescription Drug Pricing Disclosure and Reporting
- Transparency in Pricing
- Balance Billing Prohibitions
- Mental Health Parity Requirements
- Other Requirements

Introduction

HUNTON ANDREWS KURTH

- New requirements on surprise billing and transparency make significant changes
  - Many rules regulate providers, but others apply to group health plans – particularly notice and disclosure obligations
  - Federal surprise billing and transparency requirements often overlap with state insurance laws
  - Plan sponsors will need to work with third party administrators (TPAs) and health insurance issuers to ensure compliance
    - This presentation is intended to be a high-level overview of the new regulatory landscape, but is not an exhaustive survey of all of the new requirements

Overview of Legislation and Guidance

HUNTON ANDREWS KURTH

- October 2020: Transparency in Coverage (TiC) rules
- December 2020: Consolidated Appropriations Act (CAA), 2021
  - Included the No Surprises Act
- August 2021: Tri-Department FAQs
  - Provided clarification on overlaps between TiC and CAA
  - Specified extended deadlines and/or non-enforcement periods for certain requirements
- Regulations issued throughout 2021

Health Care and Prescription Drug Pricing Disclosure and Reporting

HUNTON ANDREWS KURTH

- Transparency in Coverage (TiC) Requirements
  - Rules apply to fully insured and self-insured group health plans
    - Not applicable to grandfathered health plans, plans providing only excepted benefits (e.g., dental, vision), or short-term limited-duration insurance
  - **Public Disclosure:** Plans/issuers must publicly disclose health care and prescription drug pricing information on a website in three machine-readable files
    - In-network provider negotiated rates for covered items/services
    - Historical data showing billed and allowed amounts for covered items/services, including prescription drugs, furnished by out of network (OON) providers
    - Negotiated rates and historical net prices for prescription drugs furnished by in-network providers

Health Care and Prescription Drug Pricing Disclosure and Reporting

HUNTON ANDREWS KURTH

- CAA Prescription Drug Reporting Requirements
  - Group health plans and health insurance issuers are required to report prescription drug cost information annually to the government
    - Applies to grandfathered plans
  - Significant overlap with TiC rules for public disclosure
  - Details not yet provided on *how* the reports will be submitted
  - Information reported can be aggregated at a state/market level, rather than separately for each plan
  - HHS will be required to issue a report on its website, which plan sponsors will be able to use in future RFPs or to revise prices in their current prescription drug contracts

Health Care and Prescription Drug Pricing Disclosure and Reporting

HUNTON ANDREWS KURTH

- CAA Prescription Drug Reporting Requirements (cont.)
  - Required information:
    - General information regarding the plan or coverage;
    - Enrollment and premium information (incl. average monthly premiums paid by employees versus employers);
    - The 50 most frequently dispensed brand prescription drugs;
    - The 50 costliest prescription drugs by total annual spending;
    - The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous year;
    - Total health care spending under the plan, broken down by type of cost, including prescription drug spending by enrollees versus employers/issuers;
    - Prescription drug rebates/fees/other remuneration paid by drug manufacturers in each drug class, and for each of the 25 drugs with highest rebates, and the impact on premiums and out-of-pocket costs.

Health Care and Prescription Drug Pricing Disclosure and Reporting

HUNTON ANDREWS KURTH

- Timing of Requirements
  - Enforcement of TiC requirement to publish machine-readable files related to prescription drugs deferred pending further guidance
    - Government is considering whether the requirement remains appropriate in light of additional CAA requirements
  - Enforcement of public disclosure requirements for in-network rates and OON allowed amounts/billed charges deferred until ***July 1, 2022***
    - Once enforcement begins, will apply to plan years beginning on or after January 1, 2022
  - CAA prescription drug reporting requirements originally effective December 27, 2021, delayed until ***December 27, 2022***
    - First report will include information for 2020 and 2021
    - Reporting will be required on June 1 of each year thereafter

Transparency in Pricing

HUNTON ANDREWS KURTH

- TiC Participant Disclosure Requirements
  - Requires plans/issuers to provide the following information to participants, beneficiaries, or enrollees through an internet-based self-service tool and in paper form (upon request):
    - Estimated cost-sharing liability for a requested covered item or service;
    - Accumulated amounts of the participant's accrued deductible or OOP payment amount, as well as accrued items or services for which the plan imposes a cumulative limitation;
    - Negotiated rate for in-network items or services;
    - OON allowed amount for OON covered items or services;
    - Lists of covered items and services that are part of a bundled payment arrangement;
    - Notice of items and services subject to a "prerequisite" (i.e., concurrent review, prior authorization, and step-therapy or fail-first protocols); and

Transparency in Pricing

HUNTON ANDREWS KURTH

- TiC Participant Disclosure Requirements Cont.
  - Disclosure notice that includes the following in plain language:
    - Explanation that OON providers may bill consumers the difference between provider's billed charges and sum of plan payments and copayments/coinsurance if permitted under state law
    - Statement that actual charges may vary from estimate
    - Statement that estimated cost-sharing is not a guarantee of coverage
    - Disclosure of whether copayment assistance counts toward deductible/out of pocket max
    - Statement that preventive services may not be subject to cost-sharing if the plan can't determine whether the request is for preventive or nonpreventive items/services
  - Two tranches:
    - 500 items/services listed in the rules: ***January 1, 2023***
    - All items and services: ***January 1, 2024***

Transparency in Pricing

HUNTON ANDREWS KURTH

- No Surprises Act (NSA) - Price Comparison Tool
  - Requires group health plans to offer a tool that compares the amount of cost sharing that the individual would be responsible for paying for a specific item/service by a participating provider in a plan year within a specific geographic region.
    - Must be available by phone and online.
  - Originally effective January 1, 2022, delayed until ***January 1, 2023***.
    - Delayed enforcement to align with the effective date of the TiC rules and to address duplication with the TiC requirements.
    - Plans and issuers should continue to make existing pricing tools or programs accessible and to work toward updating the standards of these tools and programs to meet the minimum requirements.

Transparency in Pricing

HUNTON ANDREWS KURTH

- NSA Medical ID Card Requirements
  - Effective date – ***January 1, 2022***
  - Requires group health plans or health insurance issuers to provide participants with a physical or electronic ID card that includes the following information:
    - In-network and OON deductibles
    - OOPM limitation applicable for the plan or coverage; and
    - A telephone number and website address for assistance, such as information related to hospitals and urgent care facilities that have a contractual relationship with the plan.
  - The August 2021 FAQs provide that plans and insurance issuers are expected to implement the requirements above using a good faith, reasonable interpretation of the statute until regulations are adopted.
    - Will not be out of compliance if the physical or electronic ID cards include the major medical deductible and OOPMs as long as there is a consumer assistance phone number and website, or a Quick Response (QR) code or hyperlink available on the card to access deductibles and OOPM limits.

Transparency in Pricing

HUNTON ANDREWS KURTH

- NSA Provider Directory Requirements
  - Requires group health plans to ensure that their in-network provider directories are accurate and that participants can access the directory online or by phone. The directory must include:
    - A process to verify the accuracy of provider information in the directory at least every 90 days,
    - A procedure for removing a provider/facility information that can't be confirmed,
    - A procedure to update a provider's information within 2 business days of receiving an update from a provider.

Transparency in Pricing

HUNTON ANDREWS KURTH

- NSA Provider Directory Requirements Cont.
  - The directory must also include:
    - A response protocol to respond to a participant's request (by phone) regarding whether a provider/facility is in-network within 1 business day after such call is received, through a written electronic or print communication (as requested).
      - Communications must be kept in the individual's file for at least 2 years following a response.
    - A database on the public website of the plan (or insurance issuer) that contains:
      - a list of each provider and facility that has a direct or indirect contractual relationship with the plan or coverage, and
      - provider directory information, including the name, address, specialty, phone number and digital contact information for the provider or facility.

Transparency in Pricing

HUNTON ANDREWS KURTH

- NSA Provider Directory Requirements Cont.
  - A participant who relies on any inaccurate provider directory information regarding network status will be responsible for only the in-network cost-sharing amount, deductible or OOPM, if any.
  - The August 2021 FAQs provide that a plan or issuer will not be out of compliance as long as the plan/issuer:
    - imposes only a cost-sharing amount that is not greater than the cost-sharing amount that would be imposed for items and services furnished by a participating provider, and
    - counts those cost-sharing amounts toward any deductible or out-of-pocket maximum.
  - Effective date – ***January 1, 2022***

Transparency in Pricing

HUNTON ANDREWS KURTH

- NSA Advance EOB Requirement
  - ***Delayed until future rulemaking***
  - Required plans or health insurance issuers to send participants, upon request, an advanced explanation of benefits (EOB) before scheduled care.
  - The timing for when the plan or insurance issuer must provide an advanced EOB depended on when the patient schedules the service or requests the estimate.
  - August 2021 FAQs indicated that compliance was likely not possible by January 1, 2022. As such, the Departments have delayed enforcement of this provision pending future rulemaking.

Transparency in Pricing

HUNTON ANDREWS KURTH

- Continuity of Care Requirements
  - Effective date – ***January 1, 2022***
  - For a "continuing care patient" who is receiving certain types of in-network care, a plan must provide continued in-network coverage to the participant if his/her treating in-network provider leaves the network.
  - A continuing care patient is a person who is:
    - undergoing a course of treatment for a serious and complex condition from the provider or facility;
    - undergoing a course of institutional or inpatient care from the provider or facility;
    - scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
    - pregnant and undergoing a course of treatment for pregnancy from the provider or facility; or
    - determined to be terminally ill, as determined under the Social Security Act, and is receiving treatment for the illness from the provider or facility.
  - Continued coverage ends the earlier of (a) 90 days after notice of the change in network status of a treating provider is provided to the participant or (b) the date the participant is no longer a continuing care patient.
  - Continuing care requirement does not apply to "for-cause" terminations of a provider who fails to meet applicable quality standards or for fraud.
  - Plans, issuers, providers, and facilities are expected to implement the requirements above using a good faith, reasonable interpretation of the statute.

Balance Billing Prohibitions

HUNTON ANDREWS KURTH

- The "No Surprises Act" is intended to protect individuals from surprise medical bills that arise in certain scenarios:
  - OON emergency care
  - Ancillary services (e.g., anesthesia) provided by OON providers at in-network facilities
  - OON care provided at in-network facilities without the patient's advance informed consent
  - Air ambulances
- If provided by an OON provider, the participant can only be required to pay the *in-network* cost sharing amount
- Amount paid must count towards deductible and out of pocket maximum in the same manner as if made for an in-network provider
- Providers prohibited from balance billing plan participants for any remaining amounts
- Effective ***January 1, 2022***

Balance Billing Prohibitions

HUNTON ANDREWS KURTH

- External review process expanded to cover adverse determinations involving surprise billing protections
  - Includes ACA grandfathered plans
- Waiver of balance billing protections
  - Notice and consent process must be followed, using standard forms and including required information
  - Only permitted in non-emergency situations
  - Waivers generally *may not* be requested in the following scenarios:
    - For care for unforeseen, urgent medical needs that arise at the time an item or service is provided; and
    - For certain ancillary services (e.g. anesthesia, radiology) or where there is no in-network provider available in the facility;

Balance Billing Prohibitions

HUNTON ANDREWS KURTH

- Air Ambulance Services – reporting obligation
  - Plans and health insurance issuers will be required to provide detailed claims data to the government on air ambulance service provided
    - Reports due no later than 90 days after the last day of the first calendar year on or after the date on which the final rule is issued
    - Under proposed rules issued in September 2021:
      - 2022 data to be reported by 3/31/2023
      - 2023 data to be reported by 3/30/2024

Balance Billing Prohibitions

HUNTON ANDREWS KURTH

- Dispute Resolution
  - Establishes "Independent Dispute Resolution" (IDR) process
    - Parties (provider and plan/issuer) first engage in open negotiation
    - If parties cannot reach agreement, they can submit to IDR process
      - Select IDR provider
      - Each of the parties submits an offer for payment
      - IDR entity selects one of the payment offers
  - State laws may apply instead of federal IDR in some states (primarily for fully-insured plans)
  - Separate dispute resolution procedures for self-pay or uninsured participants
  - Some uncertainty on IDR rules
    - Regulations issued in July and October 2021
    - In February 2022 a federal district court struck down portions of the new IDR provisions (other provisions remain in place)
    - The DOL then issued a memo stating that it would withdraw guidance based on the invalidated portions of the rules, but that other portions of the No Surprises Act remain in effect

Balance Billing Prohibitions

HUNTON ANDREWS KURTH

- Participant Notice – Effective ***January 1, 2022***
  - Notice must be made available to participants, beneficiaries, and enrollees:
    - Publicly available
    - Posted on the group health plan/issuer's public website
    - Included on each explanation of benefits
  - The notice should include information on the following:
    - Federal requirements prohibiting balance billing
    - Other applicable state laws on out-of-network balance billing
    - Information to contact appropriate state and federal agencies if an individual believes the provider or facility has violated the prohibition against balance billing
  - The government has provided a model notice
  - No current regulations; while regulations may be issued in the future, plans/issuers are expected to use a good faith reasonable interpretation of the law
    - Use of the model notice is considered good faith compliance

Mental Health Parity Requirements

HUNTON ANDREWS KURTH

- Effective Date – ***February 10, 2021***
- The CAA sets forth new compliance requirements for group health plans and health insurance issuers under the Mental Health Parity and Addiction Equity Act (MHPAEA).
- Group health plans and insurance issuers that provide both medical/surgical benefits and mental health/substance abuse benefits (MH/SUD), and which impose nonquantitative treatment limitations (NQTLs) on mental health/ substance abuse benefits, must perform and document a detailed comparative analysis of how these NQTLs are applied to both types of benefits.
- Must be made available to a state authority, DOL or HHS, upon request, beginning 45 days after the enactment of the CAA.
- Does not address how long a plan would have to respond following such a request.

Mental Health Parity Requirements

HUNTON ANDREWS KURTH

- The analysis must include:
  - A clear description of the specific NQTL, plan terms, and policies at issue.
  - Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.
  - Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
  - To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
  - The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

Mental Health Parity Requirements

HUNTON ANDREWS KURTH

- The analysis must include:
  - If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
  - If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.
  - A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.
  - The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses.

Mental Health Parity Requirements

HUNTON ANDREWS KURTH

- If DOL/HHS reviews the comparative analysis and determines that the plan or issuer is not in compliance, the plan or issuer must specify the actions it will take to be in compliance and, within 45 days, provide the agency with a new comparative analysis that demonstrates compliance.
- After end of the 45-day corrective action period, if DOL/HHS make a final determination that the plan or issuer is still not in compliance, not later than 7 days after this determination, the plan or issuer must notify all individuals enrolled in the coverage that the coverage is determined to be noncompliant with MHPAEA.
- The legislation and guidance do not specify the consequence for noncompliance.

Other Requirements

HUNTON ANDREWS KURTH

- Gag clause removal
  - Effective ***December 27, 2020***
  - Health plans/issuers may not enter into any agreement that would prevent the plan/issuer from any of the following:
    - Disclosing provider-specific cost or quality-of-care information or data to referring providers, plan sponsor, enrollees, or eligible individuals
    - Electronically accessing de-identified claims information or data
    - Sharing the above information or data with a business associate
  - Requires annual attestation of compliance
  - August 2021 guidance indicated that the Departments do not expect to issue regulations, but do intend to issue implementation guidance
    - Until guidance is issued, good-faith reasonable interpretation required

Other Requirements

HUNTON ANDREWS KURTH

- Disclosure of direct and indirect compensation by brokers and consultants
  - Applies to contracts executed/renewed on/after ***December 27, 2021***
  - Applies ERISA Section 408(b)(2) requirement to health plans
    - Includes dental/vision plans
  - Covered service providers required to provide disclosure of specific information, including the following:
    - Description of service to be provided
    - If applicable, statement that the covered service provider (or affiliate/subcontractor) reasonably expects to provide services as a fiduciary
    - Description of all compensation received directly from group health plan
    - Description of all indirect compensation the covered service provider (or affiliate/subcontractor) reasonably expects to receive in connection with the services
    - Description of the arrangement between the payor and covered service provider (or affiliate/subcontractor) pursuant to which indirect compensation is paid
  - "Covered service provider" includes brokerage and consulting services

Summary of Changes and Deadlines

HUNTON ANDREWS KURTH

Requirement	Effective Date
Requirement for plans/issuers to publish machine readable files relating to prescription drug pricing	Delayed pending future rulemaking.
Requirement to publish machine-readable files of in-network rates and out-of-network allowable amounts and billed charges	Deferred enforcement until July 1, 2022.
Requirement for a health plan or issuer to make a price comparison tool available via phone and on plan or issuer's website for plan years beginning on or after January 1, 2022	Delayed. Now effective for plan years beginning on or after January 1, 2023.
Requirement to provide an Advanced Explanation of Benefits ("EOB")	Delayed pending future rulemaking.
Requirement to report pharmacy benefit and drug cost information, including expenditures, the 50 most frequently dispensed brand drugs, total paid claims for said drugs, and the impact of rebates on premiums and fees, by the first deadline for reporting on December 27, 2021 or the second deadline for reporting on June 1, 2022	Deferred enforcement pending further guidance or regulations, but should be prepared to report by December 27, 2022.
Requirement to provide NSA balance billing notice	Effective January 1, 2022
Mental Health Parity comparative analysis requirements	Effective February 10, 2021

Summary of Changes and Deadlines

HUNTON ANDREWS KURTH

Requirement	Effective Date
Requirement to provide updated ID cards that include the applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance	Effective January 1, 2022.
Requirement to establish a process for maintaining accurate provider directories, which includes a process to update and verify the accuracy of provider directory information and a protocol for responding to requests by telephone and electronic communication from a participant, beneficiary, or enrollee about a provider's network participation status	Effective January 1, 2022.
Requirement to establish continuity of care provisions that protect participants when terminations of certain contractual relationships result in changes in provider or facility network status	Effective January 1, 2022.
Prohibition against gag clauses that prevent plans and issuers from entering into an agreement with a provider, provider network, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from (1) providing provider-specific cost or quality of care information; (2) electronically accessing de-identified claims data for each participant, beneficiary, or enrollee; and (3) sharing such information, consistent with applicable privacy regulations	Effective December 27, 2020.

Upcoming Webinars

HUNTON ANDREWS KURTH

Executive Compensation Academy

- Title: Topic TBD
- When: April 14, 2022
- Time: 10:00 am – 11:00 am CT
  11:00 am – 12:00 pm ET

Employee Benefits Academy

- Title: Investment Policy Basics and Considerations for 401(k) plans
- When: May 26, 2022
- Time: 10:00 am – 11:00 am CT
  11:00 am – 12:00 pm ET