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Deadlines Fast Approaching for Health Plans to Comply With the Consolidated Appropriations Act, 2021 and Transparency Rule

November 16, 2021

As discussed in our prior Client Alert, the Consolidated Appropriations Act, 2021 (the "CAA") includes a number of new requirements for group health plans, including price transparency, new reporting requirements, and limitations on surprise billing and balance billing. The Departments of Labor, Health and Human Services, and the Treasury (the "Departments") have begun issuing regulations and other guidance to implement the CAA's changes, most of which become effective for plan years beginning on or after January 1, 2022. The Departments have also provided guidance on upcoming deadlines to comply with the final rule on transparency of medical pricing (the "Transparency Rule"), which requires most group health plans (including self-insured plans) to disclose certain information. Employers should ensure the changes are implemented by the effective dates and that health plans, summary plan descriptions ("SPDs") and service agreements are amended to address the CAA and Transparency Rule.

This Client Alert summarizes the major changes included in the CAA and Transparency Rule and then identifies next steps for employers as they bring their health plan documents and operations into compliance.

CHANGES UNDER THE CAA

Applicability to Grandfathered Plans

The Departments emphasize that various protections in the CAA apply to grandfathered plans, including those discussed in this "Changes Under the CAA" section.

Preventing Surprise Medical Bills for Emergency Services and Air Ambulance Services

New regulations require group health plans to cover benefits for services in hospital emergency rooms ("ERs") and independent freestanding emergency departments (such as urgent care facilities) ("IFEDs") without prior authorization, without regard to whether the provider or facility is in-network or out-of-network, without limiting what constitutes an emergency medical condition based solely on diagnosis codes, and without regard to other general plan exclusions. The regulations also explain how coverage must be provided for emergency services that are provided by an out-of-network provider or facility, such as the applicable co-pay and the amount that the plan is responsible for paying. Importantly, the plan must count any cost-sharing payments a participant makes for emergency services that are

provided by out-of-network providers or facilities toward the in-network deductible and out-of-pocket maximums as if the emergency services were furnished in-network.

The regulations include similar requirements for air ambulance services.

Balance Billing For Emergency Services and Air Ambulance Services

Under new regulations, if a participant is furnished emergency services for an emergency medical condition during an ER or IFED visit, an out-of-network facility or out-of-network provider typically cannot bill or hold the participant liable for a payment amount that exceeds the participant's cost-sharing requirement. Those limitations do not apply to most items and services if the provider or facility follows detailed notice and consent requirements. However, even if the participant consents to be balance billed, out-of-network providers and facilities cannot balance bill for items or services that result from an unforeseen, urgent medical need at the time a service is furnished.

New regulations include similar rules for out-of-network air ambulance service providers to prevent them from balance billing.

Preventing Surprise Medical Bills for Non-Emergency Services an Out-of-Network Provider Performs at an In-Network Facility

If an out-of-network provider furnishes services to a participant at an in-network facility, then the plan must cover those services in a particular way, as specified in new regulations. For example, the participant's cost-sharing requirement cannot be greater than the amount that would apply if an in-network provider furnished the services, and the cost-sharing payments must count toward any in-network deductible and out-of-pocket maximums. The regulations explain how to calculate the plan's payment obligations in these situations. The regulations also include detailed notice, consent, recordkeeping, and disclosure obligations that permit an out-of-network provider to obtain a participant's informed consent to be balance billed in certain situations.

Balance Billing for Non-Emergency Services

An out-of-network provider that furnishes services at an in-network facility cannot bill or hold a participant liable for a payment amount that exceeds the cost-sharing requirement for the service. However, that prohibition does not apply to most items and services if the provider satisfies certain notice and consent criteria. However, even if the participant consents to be balance billed, out-of-network providers cannot balance bill for services that result from an unforeseen, urgent medical need at the time a service is furnished.

Independent Dispute Resolution Process

New regulations establish a detailed independent dispute resolution ("IDR") process under which an out-of-network provider, emergency facility, or air ambulance service provider and a health plan can determine the amount the plan pays for an item or service if the parties cannot agree to the amount through negotiations.

Complaints Process for Surprise Medical Billing

Regulators established a new process to receive and resolve complaints that a group health plan may be failing to meet the surprise billing and transparency regulations. Among other things, regulators may refer the complaint to another appropriate federal or state regulatory authority or investigate the plan for enforcement action.

Choice of Health Care Professionals

The CAA extends the applicability of the Affordable Care Act's ("ACA") choice of healthcare provider protections to grandfathered plans so that grandfathered and non-grandfathered plans that require or provide for a participant to designate a participating primary care provider must permit specified types of primary care providers. Plans must provide a notice in the SPD informing participants of their rights relating to designating a primary care provider.

Internal Claims and External Reviews

Grandfathered and non-grandfathered plans must apply the external review process for an adverse benefit determination that involves consideration of whether the plan is complying with certain surprise billing and cost-sharing protections. Under the ACA, grandfathered plans were not subject to the external review process, so this is a major addition for such plans.

Air Ambulance Reporting

Proposed rules require reporting of specified information relating to air ambulance services for the 2022 and 2023 calendar years. The proposed reporting deadlines are March 31, 2023 (for 2022) and March 30, 2024 (for 2023). A group health plan may contract with an insurer or third-party administrator to perform the reporting, but the plan remains liable if the reporting is not performed correctly.

Provisions With Delayed Implementation or "Good Faith" Compliance Requirements

Prohibition on Contractual Gag Clauses

The Departments do not expect to issue regulations on the "no gag clause" rule. However, the Departments intend to provide guidance on how to submit attestations of compliance starting in 2022. Plans must implement the prohibition on gag clauses using a good faith, reasonable interpretation of the law, effective December 27, 2021.

Price Comparison Tools

Originally, health plans were required to offer price comparison guidance by telephone and an internet tool starting January 1, 2022. The Departments intend to issue regulations and will defer enforcement of the CAA's price comparison tool requirements until January 1, 2023.

ID Cards

Health plans are required to include specified information on physical and electronic ID cards beginning January 1, 2022. The Departments intend to issue regulations to implement those requirements. Until

regulations are issued, plans must use a good faith, reasonable interpretation of the ID card requirements, based on factors specified by the Departments.

Good Faith Cost Estimates

When an individual schedules an appointment, healthcare providers are required to notify the individual (and, if applicable, the individual's health plan) of a good faith estimate of the expected charges for the items and services. Regulators intend to issue regulations to implement this requirement. Until regulations are issued, regulators will not enforce the requirement that healthcare providers provide a good faith estimate to individuals enrolled in a health plan.

Advanced Explanation of Benefits

Health plans were originally required to provide advanced explanation of benefits ("EOBs") starting January 1, 2022. The Departments intend to propose regulations regarding advanced EOBs after that date. Until regulations are issued, the Departments will not enforce the advanced EOB requirements.

Provider Directories

The Departments intend to issue regulations to implement the provider directory requirements. Until regulations are issued, health plans must use a good faith, reasonable interpretation of the provider directory requirements. In general, if a participant is incorrectly told a provider or facility is in-network when it is actually out-of-network, a plan may only charge the in-network cost-sharing amounts and must count those cost-sharing amounts toward any deductible and out-of-pocket maximums.

Balance Billing Disclosures

The Departments intend to issue additional guidance regarding balance billing requirements. Until that guidance is issued, plans must implement the balance billing disclosure requirements using a good faith, reasonable interpretation based on factors the Departments specified.

Continuity of Care

The Departments intend to issue regulations implementing the continuity of care requirements. Until final rules are issued, plans must implement the requirements using a good faith, reasonable interpretation of the continuity of care requirements.

Pharmacy and Drug Cost Reporting

The Departments intend to issue regulations regarding pharmacy benefit and drug cost reporting. The Departments will not enforce the requirements to report the specified information by the first reporting deadline (December 27, 2021) or the second reporting deadline (June 1, 2022), pending the issuance of regulations. Plans must be able to report the required information with respect to 2020 and 2021 data by December 27, 2022.

TRANSPARENCY RULE

Requirements for Public Disclosure – 2022

For plan years beginning on or after January 1, 2022, plans were originally required to disclose via a public website in three separate machine-readable files detailed information relating to covered items, services, and rates. The deadline for providing the first two files is now July 1, 2022 (instead of January 1) for disclosures related to in-network and out-of-network pricing. The deadline for prescription drug-related information is delayed until the Departments issue new final regulations.

Required Disclosures to Participants and Beneficiaries – 2023 and Thereafter

For plan years beginning on or after January 1, 2023, if requested by a participant or beneficiary, a group health plan must provide certain information with respect to 500 specific items and services outlined in the Transparency Rule. The information must be accurate at the time the request is made and be available through a free internet-based self-service tool or paper (if requested). The Transparency Rule requires a variety of information to be disclosed, such as an estimate of an individual's cost-sharing liability for an item or service, accumulated amounts already incurred for deductibles and out-of-pocket limits, rate information, notification that an item or service is subject to a prerequisite and a disclosure notice. For plan years beginning or after January 1, 2024, disclosures will be required for all covered items and services.

NEXT STEPS

Employers should review and amend their health plan documents and SPDs to address these new regulations. Employers should ensure the plan documents, SPDs, and other related documents:

- Explain the limitations and requirements relating to balance billing and surprise billing and ensure balance billing disclosures are provided.
- Address continuity of care requirements.
- Explain how co-payments and payment amounts will be determined when services are performed in an ER, IFED, or in-network facility by an out-of-network provider or by an air ambulance service provider.
- Include provisions relating to the circumstances under which balance billing protections may not apply and the consequences of consenting to being balance billed.
- Explain how cost-sharing, deductibles, and out-of-pocket maximums will be calculated when services are performed by out-of-network providers and facilities.
- Provide accurate information regarding a provider's in-network status and address the deductibles and cost-sharing amounts that will apply when incorrect information is provided.
- Include the disclosures relating to the right to designate a primary care provider. This is especially important for grandfathered plans, which were not previously subject to this requirement.

- Provide external review for certain adverse benefit determinations relating to surprise billing and balance billing. This is especially important for grandfathered plans, which were not previously subject to the external review requirements.

- Ensure health plan ID cards include the required information.

Plans and employers should continue working with their third-party administrators ("TPAs") and pharmacy benefit managers ("PBMs") to implement the Transparency Rule and various reporting, disclosure, and transparency obligations under the CAA. As a practical matter, most employers and their plans will not have access to the information or resources necessary to provide the required disclosures or reports. As such, employers should:

- Consider contracting with the applicable insurer, TPA, or PBM to perform the reporting and disclosure-related services, including developing and hosting a website.

- Review and, if necessary, revise amendments or contracts that insurers, TPAs, or PBMs provide in connection with handling the reporting and disclosure-related services. Employers should consider obtaining specific performance and service level guarantees.

- Consider whether any of the information a plan is required to report or disclose is considered proprietary or confidential under its existing contracts and, if so, amend those contracts so the information may be disclosed.

If you have any questions about the CAA, Transparency Rule, or need assistance in reviewing and updating your plan documents and service agreements, contact a member of the Kutak Rock Employee Benefits Practice Group.

Contacts

John E. Schembari
Omaha
402.231.8886
john.schembari@kutakrock.com

Michelle M. Ueding
Omaha
402.661.8613
michelle.ueding@kutakrock.com

William C. McCartney
Irvine
949.852.5052
william.mccartney@kutakrock.com

P. Brian Bartels
Omaha
402.231.8897
brian.bartels@kutakrock.com

Cindy L. Davis
Minneapolis
612.334.5000
cindy.davis@kutakrock.com

Alexis L. Pappas
Omaha
402.661.8646
alexis.pappas@kutakrock.com

Jeffrey J. McGuire
Omaha
402.661.8647
jeffrey.mcguire@kutakrock.com

Ruth Marcott
Minneapolis
612.334.5044
ruth.marcott@kutakrock.com

Amanda R. Cefalu
Minneapolis
612.334.5000
amanda.cefalu@kutakrock.com

Sevawn Foster Holt
Little Rock
501.975.3120
sevawn.holt@kutakrock.com

Nathan T. Boone
Minneapolis
612.334.5014
nathan.boone@kutakrock.com

John J. Westerhaus
Omaha
402.231.8830
john.westerhaus@kutakrock.com

Daniel C. Wasson
Omaha
402.346.6000
daniel.wasson@kutakrock.com

Emily P. Dowdle
Omaha
402.661.8683
emily.dowdle@kutakrock.com

James E. Crossen
Minneapolis
612.334.5000
jim.crossen@kutakrock.com

Robert J. Hannah
Omaha
402.661.8667
robert.hannah@kutakrock.com