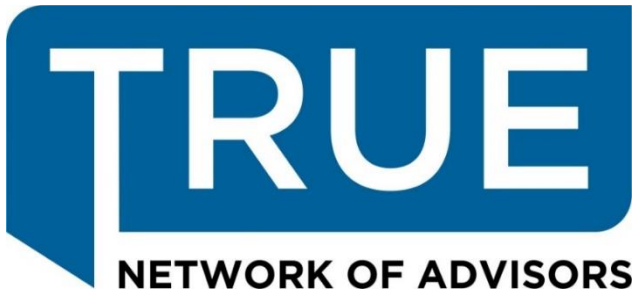
Consolidated Appropriations Act, 2021 (CAA) Compliance Update: What Employers Need to Know



Presented By
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Agenda

- Transparency in Coverage Regulations
- No Surprises Act: Emergency Services
- Mental Health Parity Comparative Analysis
- Reporting on Prescription Drug Costs
- Advanced EOBs and ID Cards
- Notice of Continuity of Care
- Price Comparison Tool
- Updated Provider Directories
- Prohibition on Gag Clauses
- Retirement Plan Provisions

Transparency in Coverage: Public Disclosures

- Non-grandfathered plans and insurers must disclose, through separate machine-readable files on a public website:
  - Negotiated rates for all covered services and items between the plan/insurer and in-network providers
  - Historical payments to, and billed charges from, out-of-network providers for covered services and items
  - Negotiated rates and historical net prices for all covered prescription drugs
    - This third requirement has been delayed indefinitely
- This does not apply to grandfathered plans, account-based plans, excepted benefits, short-term limited duration insurance, or retiree-only plans

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Transparency in Coverage: Public Disclosures

- Effective for plan years beginning on or after 1/1/22; **enforcement begins 7/1/22**
- Next Steps:
  - Self-funded plans can enter into a written agreement with a TPA/vendor providing that the TPA will make the disclosure on behalf of the plan
    - Plan Sponsor will be liable in the event disclosure is not done correctly or not updated timely
    - Plan Sponsor must continue to monitor
  - Fully-insured plans can similarly enter into a written agreement with the insurer
    - Plan Sponsor will not be liable for resulting compliance issues

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Transparency in Coverage: Disclosures to Participants and Beneficiaries

- Non-grandfathered health plans and insurers must provide to participants and beneficiaries certain personalized cost-sharing information and underlying negotiated rates for all covered services and items:
  - Estimated cost-sharing liability
  - Participant's accumulated amounts toward deductibles and OOP limits
  - INN negotiated rates & OON allowed amounts
  - Items and services subject to bundled payment arrangements
  - Notice of prerequisites (e.g., prior authorization)
  - Disclaimer notice
- Provide through an internet-based self-service tool with search capabilities, or paper format, if requested

Transparency in Coverage: Disclosures to Participants and Beneficiaries

- **DOL Model Notice:** 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
- **This does not apply to grandfathered plans, account-based plans, excepted benefits, short-term limited duration insurance, or retiree-only plans**
- **Effective for plan years beginning on or after 1/1/23 for 500 services and items selected by the Departments**
- **Effective for plan years beginning on or after 1/1/24 for all other covered services and items**

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Transparency in Coverage: Disclosures to Participants and Beneficiaries

- **Next Steps**:
  - Self-funded plans can enter into a written agreement with a TPA/vendor providing that the TPA will make the disclosure on behalf of the plan
    - Plan Sponsor will be liable in the event disclosure is not done correctly or not updated timely
    - Plan Sponsor must continue to monitor
  - Fully-insured plans can similarly enter into a written agreement with the insurer
    - Plan Sponsor will not be liable for resulting compliance issues
- Similar to CAA Price Comparison Tool

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CAA: No Surprises Act

- Effective for plan years beginning on or after **1/1/22**, plans must cover emergency care services (i) without requiring preauthorization and (ii) at in-network cost-sharing rates, even if the provider or facility is out-of-network
  - Similarly, plans covering air ambulance services must cover a participant's out-of-network air ambulance service at in-network cost-sharing rates
- Applies to all group health plans, including grandfathered plans, but does not apply to excepted benefits, short-term limited-duration insurance (STLDI), or retiree-only plans
- Providers and facilities are banned from balance billing on emergency care services with prior consent

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CAA: No Surprises Act

- Plans must pay out-of-network providers, or provide notice of denial of payment, within 30 days of receiving a bill

- <u>Open Negotiation Period</u>:
  - For services furnished by out-of-network providers (where no state law determines the payment rate), following the providers' receipt of the initial payment or denial, a 30-day open negotiation period is required

- <u>Independent Dispute Resolution</u>:
  - An "independent dispute resolution" process (*i.e.*, binding arbitration) must follow for plans and out-of-network providers who cannot agree upon a rate during the open negotiation period

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CAA: No Surprises Act

External Review Requirements

- Existing ACA external review requirements apply to certain types of health plan claims following adverse benefit determinations
  - For plan years beginning on or after **1/1/22**, CAA extended the external review requirements to adverse benefit determinations relating to a surprise medical or air ambulance claims
- Generally, fully-insured plans use a state-administered external review process, while self-funded plans use a federal HHS-administered process
- CMS issued a memo explaining that the federal HHS-administered process may be used if a state's process cannot yet accommodate surprise medical or air ambulance claims (or plans cannot contract with an accredited independent review organization that can do so).

CAA: No Surprises Act

Balance Billing Disclosure

- For plan years beginning on or after **1/1/22**, plans must make publicly available, post on a public website of the plan, and include on each explanation of benefits (EOB) for an item or service with respect to which the surprise billing protections apply the following:
  - The restrictions on balance billing in certain circumstances;
  - Any applicable state law protections against balance billing;
  - The requirements under the new surprise billing rules; and
  - Information on contacting appropriate state and federal agencies
- A model notice is available on the DOL's website

Air Ambulance Reporting

- Plans must submit data regarding air ambulance coverage to the DOL, DOT, and HHS within 90 days after end of calendar year
- Reports due for calendar year **2022 by 3/31/23**, or for calendar year **2023 by 3/30/24**

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Mental Health Parity Comparative Analysis

- Effective **February 10, 2021**
- Applicable to group health plans that offer mental health or substance use disorder (MH/SUD) benefits
- If the plan imposes non-quantitative treatment limitations (NQTLs) on MH/SUD benefits, the plan must perform and document a comparative analysis of NQTLs on MH/SUD benefits vs. medical/surgical benefits
- Analyses must be available to agencies upon request, and agencies must request at least 20 per year
- DOL guidance:
  - DOL's Webpage on MH/SUD Parity, which includes links to the regulations and additional guidance
  - FAQs
  - Self-Compliance Tool

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Mental Health Parity Comparative Analysis

- In late January 2022, the DOL, DOT, and HHS issued their first "Report to Congress" on group health plan and issuer compliance with the MHPAEA, specifically with regard to the required comparative analysis of NQTLs
- The 2022 report highlights DOL's enforcement efforts during 2021, including sending the following:
  - 156 letters requesting comparative analyses from plans and insurers regarding 216 separate NQTLs
  - 80 insufficiency letters
  - 30 initial determination letters finding that 48 NQTLs violated the MHPAEA
- Result → All plans and insurers submitted insufficient comparative analyses
- Practical impact / considerations

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CAA: Reporting on Prescription Drug and Health Care Spending

- Health plans and insurers must annually report on plan medical costs, prescription drug spending, premiums, and manufacturer rebates received by the plan
- Submissions are based on the "reference year," which is the calendar year immediately preceding the calendar year in which the submission is due
- *Delayed enforcement* → **2020 and 2021 calendar year data is due by 12/27/22**
  - Thereafter, annual reporting is due by **June 1 of the following year** (*e.g.*, 2022 data is due by 6/1/23)
- Fully-insured and self-funded plans may satisfy reporting requirements by entering into a written agreement requiring insurer, PBM, or TPA to report on their behalf
  - But if the third-party reporting entity fails to report the required information, the plan violates the reporting requirements

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CAA: Reporting on Prescription Drug and Health Care Spending

- Plans, insurers, and TPAs may submit most of the required information on an aggregate basis by state
  - If a reporting entity submits data on behalf of more than one plan in a state, the reporting entity may aggregate data for the plans for each market segment in the state (segments are based on fully-insured versus self-funded and employer size)
- Next Steps:
  - Work with the insurance carrier, PBM, or TPA that handles prescription drug claims to ensure that they provide the required information each year in advance of the filing deadline

CAA: Price Comparison Tool

- Insurers and health plans must offer price comparison guidance over the telephone and provide an online price comparison tool that allows enrollees to compare the cost-sharing amounts owed for particular services during the plan year
  - Must be keyed to specific geographic regions and participating providers
- Does not apply to excepted benefits, STLDI, or retiree-only plans
- Effective for plan years beginning on or after 1/1/22; enforcement **delayed until 1/1/23** in light of TiC participant disclosures
- Next Steps:
  - Compliance coordination between plans and carriers/TPAs
  - Review existing tools for compliance
  - Negotiate updates to service agreements, as necessary

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CAA: Advanced Explanation of Benefits (EOB)

- Upon request or when notified, insurers and health plans must send an affected participant an advanced EOB before the participant's scheduled care
  - Network status of each provider and facility
  - The contracted rate for the services to be received (or explain how to find an INN provider)
  - The provider's good faith estimate of the costs of service
  - The amount the plan is responsible for paying
  - The expected participant cost-sharing amount
  - The participant's estimated accrued annual deductible and OOP maximum amounts
  - Any medical management requirements
  - A disclaimer

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CAA: Advanced Explanation of Benefits (EOB)

- Does not apply to excepted benefits, STLDI, or retiree-only plans
- Effective for plan years beginning on or after 1/1/22; enforcement of requirement **delayed until future rulemaking**
- Next Steps:
  - Plan sponsors will need to coordinate with their carrier or TPA to confirm that the carrier/TPA will meet this requirement for the plan
  - Any communications and representations from the carrier/TPA should be documented

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CAA: ID Card Requirement

- Insurers and health plans must include the in-network and out-of-network deductible and out-of-pocket maximum limits on participant ID cards
  - ID cards must also include a telephone number and internet website address for participants to seek assistance or additional information
  - Required for physical or electronic format
- Effective for plan years beginning on or after **1/1/22**
- Next Steps: Confirm current cards comply or coordinate with carrier or TPA to get current cards updated, as necessary
  - Plan sponsor will need to ensure cards are updated in the future for any plan changes

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CAA: Updated Provider Directory

- Insurers and health plans must establish a process to verify the accuracy of their provider databases and update the info every 90 days
  - Must be accessible by phone or through a public website
  - Must have a process to remove providers when plan cannot verify their information
  - Database must be updated within 2 business days of the plan receiving notice of changes from a provider/facility
  - Must respond to request for information in writing within 1 business day
- Effective for plan years beginning on or after **1/1/22**
- If inaccurate, participant is only required to pay in-network amounts and plan is on the hook for outstanding out-of-network amounts due
- Next Steps: Review current directory; coordinate compliance efforts; update service agreements, as necessary

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CAA: Prohibition on Gag Clauses

- Insurers and health plans are prohibited from entering into an agreement with a healthcare provider, network, TPA, or other service provider offering access to a network of providers that will restrict a plan from:
  - Providing provider-specific cost or quality of care data to referring providers, the plan sponsor, or participants;
  - Accessing electronically de-identified claims data that includes financial information, provider information, services codes, or other data elements; or
  - Sharing this information with a business associate
- Plans must submit an annual attestation to HHS confirming compliance
- Effective since CAA's enactment in 2020; however, plan attestations are due beginning in **2022**
- Next Steps: Review current service agreements and remove any gag clause provisions

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CAA: Notice of Continuity of Care

- If a participant is receiving continued care for an ongoing medical condition from a specific INN provider/facility, and the provider's status changes from INN to OON, the plan or insurer must notify the participant that he or she can continue to receive care from the provider **at the INN rate for 90 days**
  - Participant will be able to access the services for 90 days after the earlier of the date the notice is provided or until the patient is no longer a continuing care patient
  - Does not apply to a situation where a provider/facility's contract is terminated with good cause
- Effective for plan years beginning on or after **1/1/22**
- Next Steps: Coordinate who is responsible for sending notice to impacted participants and update plan documents for new rule

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CAA: Retirement Plan Provisions

- Certain optional and mandatory changes for retirement plans must be reflected in formal plan amendments by **12/31/22**:
  - New Part-Time Eligibility Rules
  - Required Beginning Date Increase
  - COVID-19-Related Distributions & Loans
  - Qualified Birth or Adoption Distributions
  - Qualified Disaster Distributions & Loans
- Next Steps: Determine what changes have been administratively implemented and prepare amendments, as necessary, by 12/31/22

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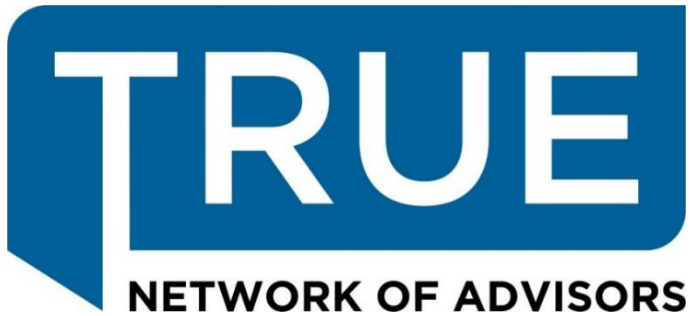
Limits for Health and Welfare Plans

	2020	2021	2022
Annual Cost Sharing Limit (self-only coverage)	$8,150	$8,550	$8,700
Annual Cost Sharing Limit (other than self-only coverage)	$16,300	$17,100	$17,400
HDHP Out-of-Pocket Maximum (self-only coverage)	$6,900	$7,000	$7,050
HDHP Out-of-Pocket Maximum (family coverage)	$13,800	$14,000	$14,100
HDHP Minimum Deductible (self-only coverage)	$1,400	$1,400	$1,400
HDHP Minimum Deductible (family coverage)	$2,800	$2,800	$2,800
Maximum Annual HSA Contributions (self-only coverage)	$3,550	$3,600	$3,650
Maximum Annual HSA Contributions (family coverage)	$7,100	$7,200	$7,300
Maximum HSA Catch-Up Contribution	$1,000	$1,000	$1,000
Health FSA Maximum	$2,750	$2,750	$2,850
Health FSA Rollover Maximum	$550	$550	$570
Employer Mandate Penalty A (Fail to Offer)	$2,570 per FTE	$2,700 per FTE	$2,750 per FTE
Employer Mandate Penalty B (Unaffordable)	$3,860 per EE	$4,060 per EE	$4,120 per EE



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