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Employee Benefits Alert

Ten Recent Updates for Self-Insured Health Plans

By Heather Stone Fletcher and Sandra R. Mihok

Wrapping up the first quarter of 2022, the Departments of Labor, Health and Human Services, and the Treasury continue to implement, enforce, and provide guidance on new legislative and regulatory requirements applicable to self-insured health plans. Many of the Departments' efforts relate to the Consolidated Appropriations Act of 2021, including the No Surprises Act, as well as continued COVID relief.

This alert outlines some of the key updates released by the Departments, and explains how they will affect self-insured plans this year. As is common with ambitious legislative changes, the Departments have delayed the effective dates of certain requirements. Therefore, the following also summarizes these delays and any additional guidance that was provided as part of the delay or thereafter.

1. Mental Health Parity Comparative Analysis Requirements and Audits

In late January, the Departments issued a report to Congress detailing their recent efforts to enforce the Mental Health Parity Equity and Addiction Equity Act ("MHPA"). MHPA requires plans that offer coverage for mental health and substance abuse to offer those benefits in a similar manner to medical and surgical benefits.

MHPA has been an enforcement priority for the Departments in the past year, spurred in part by a 2021 amendment to MHPA that requires plans and issuers to create a comparative analysis of the design and application of any non-quantitative treatment limitations ("NQTLs") for mental health and substance abuse benefits. Some examples of NQTLs include prior authorization requirements, standards for admission to a provider network, and limitations on applied behavior analysis or treatment for autism spectrum disorder. Plans were required to make these analyses available to the Departments or any participant upon request by February 10, 2021.

Given that most self-insured health plans rely heavily on their service providers to create their plan design, including any NQTLs, sponsors of self-insured health plans must rely on their service providers to provide much of the information required for the analysis. The Departments noted in the report that among the 156 audit responses from plans and issuers last year, none of the analyses contained sufficient information when they were initially received by the Departments. The report also noted that, after receiving a request from the Departments, many plans discovered that they could not solely rely on the analysis prepared by their service provider.

The Congressional report is available at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf

2. COVID National Emergency Extended; Group Health Plan Deadlines Continue to be Tolled

On February 18, 2022, President Biden extended the COVID-19 National Emergency, which was previously set to expire on March 1, 2022. The extension means that certain deadlines applicable to group health plans will continue to be tolled for a year (or if earlier, 60 days from the end of the National Emergency). Deadlines affected by the

extension include the deadlines to elect COBRA, pay for COBRA, elect HIPAA special enrollment, and file benefit claims, appeals, and external review requests.

The National Emergency was first declared on March 1, 2020. Each National Emergency declaration automatically extends for one year unless the President ends it earlier.

3. HIPAA Updates

Proposed changes to HIPAA and HITECH may affect covered entities (including self-insured health plans) and business associates in 2022. HHS issued proposed rules covering HIPAA and HITECH in early 2021 which appear to be on track to be finalized in 2022. Once adopted, the changes will likely require updates to policies and procedures, notices of privacy practices, and business associate agreements.

The proposed modifications to the HIPAA Privacy Rule are intended to improve the coordination of care and improve patient access to health records. The proposed regulations may be found at https://www.hhs.gov/sites/default/files/hhs-ocr-hipaa-nprm.pdf.

Additionally, new bipartisan legislation was introduced in February to bring health information privacy and security laws up to date with current and emerging technologies. The Health Data Use and Privacy Commission Act introduced by Sens. Bill Cassidy (R-LA) and Tammy Baldwin (D-WI) would set up a new commission tasked with reviewing the current regulations affecting health information privacy and making recommendations aligned with advances in technology since HIPAA's enactment.

4. Coverage of COVID Tests

Beginning with tests purchased on or after January 15, 2022, self-insured group health plans are required to cover the costs of up to eight over-the-counter COVID-19 tests per covered individual, per month, without a health care provider's order or an individualized clinical assessment. More detail can be found on these requirements in our prior alert: https://www.eckertseamans.com/legal-updates/health-plans-required-to-cover-costs-of-over-the-counter-covid-19-tests-beginning-january-15-2022

Since the above alert was published, the Departments issued FAQs with additional information regarding the safe harbors set forth in the prior FAQs, including a clarification that the Departments will not take enforcement action against plans that are unable to provide direct-coverage access to tests due to a supply shortage. The Departments noted that, in that circumstance, plans may continue to limit reimbursement to $12 per tests for tests purchased outside of the direct-coverage program: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-52.pdf

5. No Surprises Act Plan Design Changes

The No Surprise Act (NSA) requires health plans to offer coverage for emergency care without requiring prior authorization and without regard to whether the services are provided at an out-of-network (OON) facility or by an OON provider. The protections extend to non-emergency services provided by OON providers at in-network facilities, such as anesthesia services provided by an OON provider at an in-network hospital. The NSA requires cost-sharing to count toward any in-network deductibles and out-of-pocket maximums, and prohibits balance billing.

NSA also requires plans to provide continuity of care for certain patients with serious and complex conditions. When an in-network provider ceases to participate in a plan's network, the plan must notify and continue to cover such patients at in-network rates for 90 days. Providers are required to accept the in-network rates as payment in full for

these services, and until further guidance is issued, plans are expected to implement the requirements using a good faith interpretation of the law.

While these requirements are already effective for most plans, we are now seeing updated benefit booklets from TPAs with the revised plan design changes. As most sponsors of self-insured group health plan are legally and contractually responsible for their plan design, it's important for sponsors to closely review the revised plan design for compliance.

6. Prescription Drug Benefits Reporting

The Consolidated Appropriations Act requires plans to submit information to the Departments regarding prescription drug expenditures, including information regarding the most frequently dispensed drugs and associated costs, as well as information regarding the impact of prescription drug rebates. The reporting covers other information as well, including total spending by the plan on hospital, provider and clinical service costs.

The Departments intend to issue regulations regarding the requirements, and have deferred enforcement to report the required information until further guidance is issued. However, the Departments encouraged plans to work to ensure that they can report 2020 and 2021 information by December 27, 2022.

Plan sponsors must heavily rely on their TPAs to produce the reports, and therefore should insist on contract terms regarding production of the reports.

7. Transparency in Coverage Reporting

The Transparency in Coverage Regulations require group health plans to publicly disclose information regarding in-network provider rates, out-of-network allowed amounts and billed charges, and rates and prices for prescription drugs.

The Departments deferred enforcement of the disclosure of in-network rates and out-of-network amounts until July 1, 2022. The Departments further delayed enforcement of the prescription drug disclosure, and signaled that those requirements may be withdrawn completely, given overlapping requirements enacted as part of the Consolidated Appropriations Act (discussed above). See the following Q&As for more information: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf

As with the Consolidated Appropriations Act reporting, plan sponsors must heavily rely on their TPAs to produce the reports, and therefore should insist on contract terms regarding production of the reports.

8. New Participant Disclosures Delayed

- **Advance EOBs**

The Consolidated Appropriations Act requires plans to provide advance EOBs to participants that include significant information regarding network status of providers, contracts rates, and good faith estimates of cost-sharing. In order to provide the EOBs, plans will need to obtain information from providers. The Departments have delayed enforcement of this provision until relevant regulations are issued.

- **Self-Service Price Compare Tools**

The Transparency in Coverage Regulations and the Consolidated Appropriations Act require plans to make an online self-service tool available to participants. Plans are also required to provide comparison information via paper and telephone. The Transparency in Coverage Regulations and the Consolidated Appropriations Act had

different effective dates, but the Departments indicated in guidance that they would not enforce the requirements until January 1, 2023.

9. ID Card Requirements

Effective for plan years beginning on or after January 1, 2022, the Consolidated Appropriations Act required plans to include information regarding cost-sharing on ID cards. The Departments have indicated that they will issue guidance regarding these requirements in the future, but until future guidance is issued, plans should reasonably comply with the requirements. However, the Departments offered an example that would be considered to comply with the requirements. In the example, the plan includes the following information on any physical or electronic ID card: the applicable major medical deductible and applicable out-of-pocket maximum, as well as a telephone number and website address for individuals to seek consumer assistance and access additional applicable deductibles and maximum out-of-pocket limits. Additional deductibles and out-of-pocket maximum limits could also be provided on a website that is accessed through a Quick Response code (commonly referred to as a QR code) on the participant's, beneficiary's, or enrollee's ID card or through a hyperlink in the case of a digital ID card.

See the following for more information: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf

10. Broker and Consultant Compensation Disclosures

The Consolidated Appropriations Act requires service providers who provide brokerage or consulting services to disclose compensation if the service provider reasonably anticipates an ERISA-covered group health plan will pay the provider more than $1,000 in direct or indirect compensation. This requirement applies to all group health plans, including dental, vision, and EAPs, among others. The compensation disclosure requirements for both the group and individual markets are effective for contracts entered into, renewed, or extended on or after December 27, 2021.

The Department of Labor issued guidance on the requirements late in 2021, which included a discussion of the entities that are required to report under the new rules. It's clear that how an entity labels or markets itself is not dispositive, and therefore, the requirements may apply to TPAs, PBMs and other administrators. Failure of a plan to obtain the disclosure will result in a prohibited transaction.

If a provider does not provide this reporting, we recommend that a plan carefully examine the services that it is receiving to ensure that it has a good faith argument that the provider is not subject to the disclosure. Plans may also want to consider adding contract provisions regarding these disclosures.

ECKERT SEAMANS ATTORNEYS AT LAW

This Employee Benefits Alert is intended to keep readers current on developments in the law, and is not intended to be legal advice. If you have any questions, please contact Heather Stone Fletcher at 412-566-6059 or hfletcher@eckertseamans.com, or Sandra Mihok at 412-566-1903 or smihok@eckertseamans.com, or any other attorney at Eckert Seamans with whom you have been working.