Transparency Next Steps

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Transparency In Coverage

Machine Readable Files

Requires health plans or issuers to publish three separate machine-readable files:

- Negotiated rates for all covered items and services between the plan or issuer and in-network providers
- Historical payments to, and billed charges from, out-of-network providers
- In-network negotiated rates and historical payment net prices for all covered prescription drugs at the pharmacy location level

Enforcement deferred until **July 2022** for the in-network and out-of-network files. Further rulemaking is pended for the prescription drug file.

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Transparency In Coverage (cont'd)

Price Comparison Tools & Cost-Share Estimators

Requires health plans or issuers to have an internet-based, self-service tool that provides real-time, personalized, out-of-pocket cost information, based on the member's plan for covered items and services furnished by a particular provider.

- For plan years **beginning on or after January 1, 2023**, plan/issuer must disclose cost-share information for 500 shoppable items and services identified within the rule.

- For plan years **beginning on or after January 1, 2024**, all covered items and services must be included in the cost-share tool.

Transparency In Coverage (cont'd)

Insurance ID Cards

Requires health plans to include the following on their plan or insurance IDs issued to enrollees:

- Amount of the in-network and out-of-network deductibles
- Out-of-pocket maximum limitations

Pending future rulemaking in 2022, plans and issuers are expected to implement the ID card requirements using a good faith, reasonable interpretation of the law. Plans and issuers may design various, but reasonable, methods to comply with the law.

Transparency In Coverage (cont'd)

Good Faith Estimates

Requires health care providers and facilities to verify – **three days in advance of service and not later than one day after scheduling of service** – what type of coverage the patient is enrolled in and provide notification of Good Faith Estimate whether or not patient has coverage.

- If the individual is enrolled in a health plan or coverage (and is seeking to have a claim for the item or service submitted to the plan or coverage), the provider must provide this notification to the individual's plan or coverage.

- If the individual is **not** enrolled in a health plan or coverage or does not seek to have a claim for the item or service submitted to the plan or coverage, the provider must provide this notification to the individual.

Enforcement has been deferred. Rulemaking expected in 2022.

Transparency In Coverage (cont'd)

Advanced EOBs

Requires plans and issuers, upon receiving a "good faith estimate" regarding an item or service to send a participant, beneficiary, or enrollee (through mail or electronic means, as requested by the participant, beneficiary, or enrollee) an **Advanced Explanation of Benefits** notification in clear and understandable language. The notification must include:

- The network status of the provider or facility
- The contracted rate for the item or service, or if the provider or facility is not a participating provider or facility, a description of how the individual can obtain information on providers and facilities that are participating
- The good faith estimate received from the provider
- A good faith estimate of the amount the plan or coverage is responsible for paying, and the amount of any cost-sharing for which the individual would be responsible for paying with respect to the good faith estimate received from the provider
- Disclaimers indicating whether coverage is subject to any medical management techniques

Transparency In Coverage (cont'd)

Accurate Provider Directories

Requires health plans to have up-to-date directories of their in-network providers, which shall be available to patients online, or within one business day of an inquiry. Plans must verify key data elements (name, address, telephone, specialty and digital contact information) every 90 days and have a process to suppress providers from the directory that do not respond.

Requires plans to make publicly available and post on their website and include on each EOB, information on prohibitions on balance billing, information related to the applicable state law, the requirements applied, and information on contacting applicable State and Federal agencies.

Requires health plans to respond to an individual who requests information on a provider's network status through a telephone call within 1 business day, in writing electronically, or in print, per individual's request.

Transparency In Coverage (cont'd)

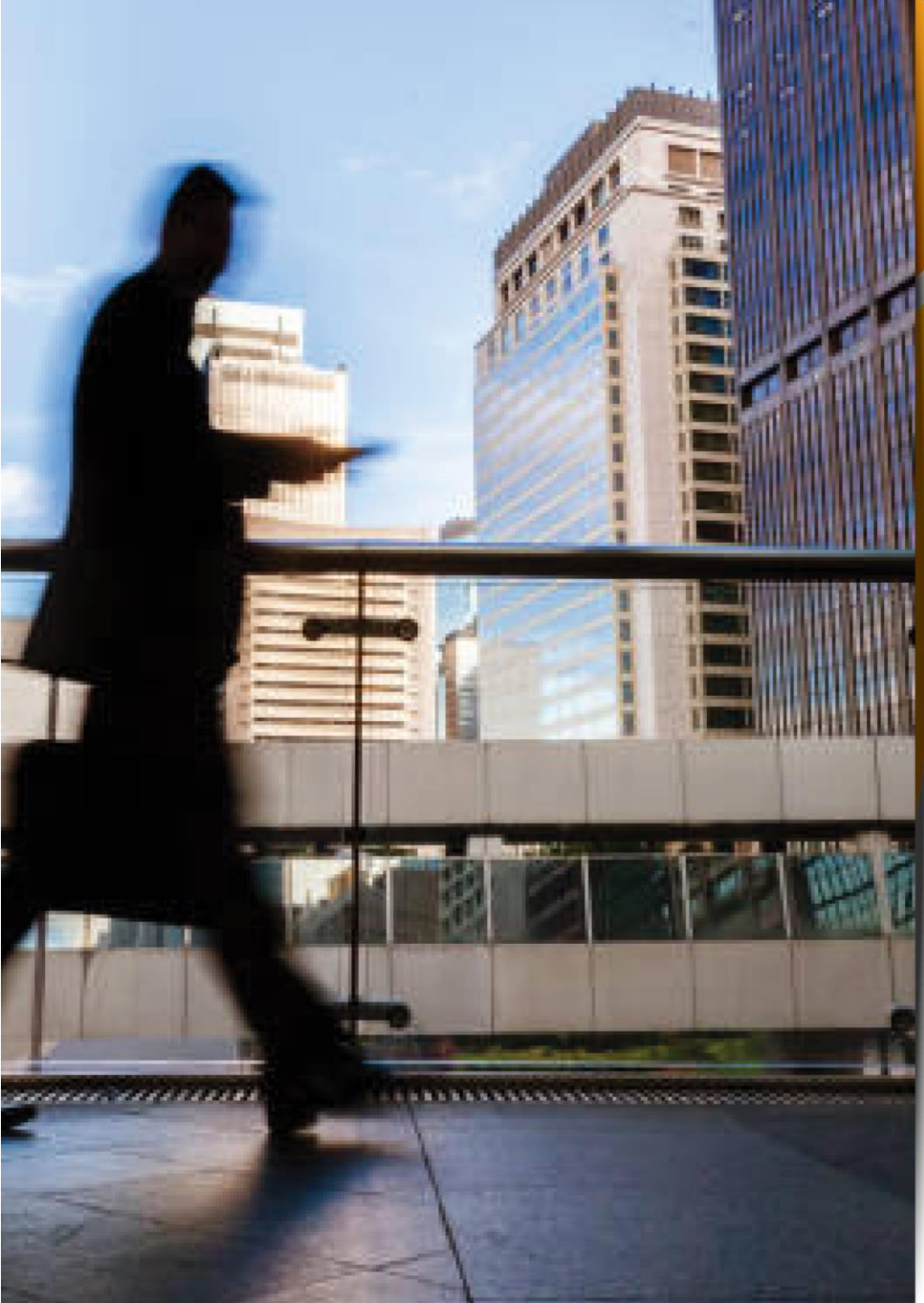
Pharmacy Benefits Reporting

These reporting requirements primarily relate to prescription drug expenditures, requiring that plans and issuers submit relevant information to the Departments, including general information regarding the plan or coverage, such as:

- The beginning and end dates of the plan year, the number of participants, beneficiaries, or enrollees, as applicable, and each state in which the plan or coverage is offered.

Plans and issuers must also report:

- The 50 most frequently dispensed brand prescription drugs, and the total number of paid claims for each such drug
- The 50 most costly prescription drugs by total annual spending, and the annual amount spent by the plan or coverage for each such drug
- The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report
- For each such drug, the change in amounts expended by the plan or coverage in each such plan year



No Surprises Act

Independent Dispute Resolution

The independent dispute resolution (IDR) process will be used by out-of-network providers, facilities, providers of air ambulance services, plans, and issuers in the group and individual markets to determine the out-of-network rate for applicable items or services covered by the **No Surprises Act** after an unsuccessful open negotiation.

There are at least six court cases pending regarding the process. A court has already ruled against the process of using the Quality Payment Amount (QPA) based on the median in-network amount.

No Surprises Act (cont.)

On February 23, 2022. a Federal District Court struck down specific provisions of the Interim Final Rule. (IFR) Specifically, the “presumption” that the IDR entity select the offer presented to it that was most closely aligned with the Qualifying Payment Amount (“QPA”) unless a party demonstrated credible evidence that the result should be materially different.

Federal Judge Jeremy Kernodle’s February ruling said nothing in the bill passed by Congress instructs arbiters to “weigh any one factor ... more heavily than the others,” indicating the rule conflicts with the bill.

Because the QPA is at the heart of the IDR process as envisioned by the IFR, the court’s decision will determine how the IDR process unfolds for both payers and providers.

The Department of Justice intends to appeal a federal judge’s ruling that sided with providers over a challenge to the surprise billing rule.

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Transparency In Coverage (cont'd)

Mental Health Parity NQTL Analysis

- The MHPAEA final regulations require that a group health plan or health insurance issuer may not impose a non-quantitative treatment limitation (NQTL) with respect to MH/SUD benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same classification.
- The CAA requires that, as of February 2021, group health plans providing mental health and substance abuse benefits and medical/surgical benefits are able to provide (upon request) a comparative analysis to the Department of Labor (DOL), to demonstrate compliance with the nonquantitative treatment limitations (NQTL) requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA).
- A MHPAEA self-compliance tool is available on the DOL's website as a resource for issuers and plan sponsors (with Section F of the tool addressing the NQTL requirements).

Transparency In Coverage (cont'd)

Mental Health Parity NQTL Analysis (Cont.)

The plans and issuers must make their comparative analyses available to the Departments or applicable State authorities, upon request, including the following information:

- The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification;
- The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits;
- The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical or surgical benefits;
- The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and
- The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

Timeline Extensions

Back in February of 2022, the President extended the National Emergency for at least another year. It was set to expire in March of 2022. Along with this extension comes an extension of certain deadlines, most notably:

- COBRA election notice, enrollment, and payment
- COBRA notifications for divorce, legal separation, child aging out, or disability
- HIPAA special enrollment notifications for adoption or birth, placement for adoption, marriage, dependent loss of health coverage, or termination of Medicaid or CHIP, or eligibility for employment assistance under Medicaid or CHIP

Timeline Extensions (cont'd)

Notice 2021-58 was issued with the following rules regarding premium payments:

- *"An individual electing COBRA **within** the initial 60-day deadline (determined without regard to the "outbreak period") has **one year and 45 days after the date of the COBRA election** to make the initial COBRA premium payment."*

- *"An individual electing COBRA **after** the initial 60-day deadline (determined without regard to the "outbreak period") generally has **one year and 105 days** (60 days to make the initial COBRA election, and 45 days to make the initial COBRA premium payment) after the date the COBRA election notice was provided to make the initial COBRA premium payment."*

Regarding subsequent premium payments, Notice 2021-58 provides that an individual has a **maximum period of one year to make a payment** while the "outbreak period" continues from the date the payment originally would have been due, including any applicable 30-day grace period.

Timeline Extensions (cont'd)

Example #1
COBRA election within the initial 60-day deadline

- On October 1, 2020, Dave has a qualifying event and receives a COBRA election notice.
- Dave elects COBRA on October 15, 2020 retroactive to October 1, 2020.
- Dave has until November 29, 2021 to make the initial COBRA payment *(1 year and 45 days after the October 15, 2020 election).*
- The initial COBRA premium payment must include **only** the payment for October 2020.
- The November 2020 payment is due by December 1, 2021 *(1 year and 30 days after the regular November 1, 2020 due date).* This rule applies to each subsequent monthly payment.

Example #2
COBRA election after the initial 60-day deadline

- On August 1, 2020, Dave has a qualifying event and receives a COBRA election notice.
- Dave has until September 30, 2021 *(1 year and 60 days after the election notice date)* to elect COBRA.
- Dave elects COBRA on February 1, 2021, retroactive to August 1, 2020.
- The initial COBRA payment is due by November 14, 2021 *(1 year and 105 days after the August 1, 2020 COBRA notice date).*
- The initial COBRA premium payment must include payments for August 2020 through October 2020.
- The November 2020 payment is due by December 1, 2021 *(1 year and 30 days after the November 1, 2020 due date).* This rule applies to each subsequent monthly payment.

Timeline Extensions (cont'd)

Example #3
Transition Relief

- On April 1, 2020, Dave has a qualifying event and receives a COBRA election notice.
- Dave elects COBRA on October 1, 2020, retroactive to April 1, 2020.
- Under the transition relief, Dave has until November 1, 2021 to make the initial premium payment. Even though November 1, 2021 is **more** than 1 year and 105 days after the April 1, 2020 COBRA notice date, November 1, 2021 is **less** than 1 year and 45 days after the October 1, 2020 election date.
- The initial COBRA payment must include the monthly premium payments for April 2020 through October 2020.
- The November 2020 payment is due by December 1, 2021 *(1 year and 30 days after the regular November 1, 2020 due date).* This rule applies to each subsequent monthly payment.

Employers that sponsor group health plans should continue to work closely with their third-party COBRA administrators to ensure compliance with the federal guidance.

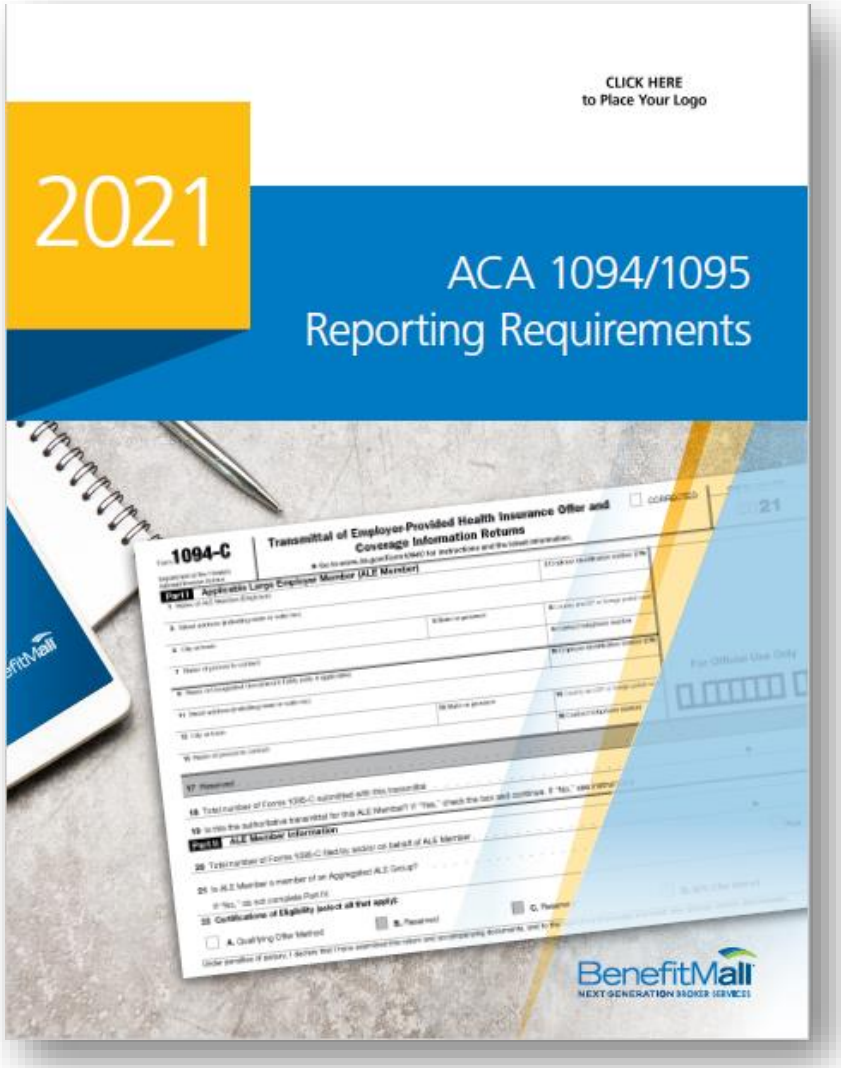
Pending Legislation & Issues of Concern

“The Family Glitch”

This provision of the ACA was interpreted by the IRS to mean that it requires an employer to offer individual coverage and based affordability at 9.5 percent of the employee’s household income(2014).

- The “glitch” occurs when one (or both) spouses are offered affordable individual employer sponsored insurance (ESI) under the IRS definition, but family coverage is either not offered or is unaffordable.
- Spouses and children of an employee offered ESI could be unable to afford the employer plan, but because it is offered to one family member, the rest are made ineligible for subsidies in the Exchanges.

Because the glitch was created by regulation, it can be fixed by regulation; new legislation is not necessary.



- White Label document so you can add your agency logo and provide to your clients

[Paid Family Leave Guide]
[Compliance Guide for Small Employers]
[Compliance Guide for Large Employers]
[State Continuation Reference Guide]
[Key ERISA Notices & Filings]
[Form 5500 Reference Guide]

- Email sam.dale@benefitmall.com for these resources

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- Welcome to **BenefitMall's Compliance Café**, where we serve up a hot cup of regulatory and legislative happenings to brokers and their clients.

- Sit back with your favorite cup of joe and listen to BenefitMall's compliance team discuss federal and state legislation and how it affects brokers and their clients.

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Thank You

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