Morgan Lewis

MEMORANDUM

TO: Board of Trustees of the Warehouse Employees Local 730 Health and Welfare Fund

FROM: Jim Kimble
Merle DeLancey

DATE: March 26, 2021

SUBJECT: Consolidated Appropriations Act Welfare Plan Changes Applicable for Multiemployer Plans

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The Consolidated Appropriations Act, 2021 (the "Act") that was signed into law on December 27, 2020 contains provisions impacting multiemployer health and welfare plans, such as protecting group health plan participants from surprise medical bills and enhancing multiemployer health and welfare plan transparency. The provisions of the Act generally apply to both grandfathered and non-grandfathered multiemployer plans, except as indicated below. We expect additional guidance from the Secretaries of HHS, Labor, and the Treasury (collectively, the Departments) which will address the Act and its requirements in greater detail.

After release of the additional guidance, we will provide more concrete examples of how the Act may impact the Fund and its participants. In the meantime, key provisions are summarized below.

NO SURPRISES ACT – COMBATTING SURPRISE MEDICAL BILLING

Within the Act is the "No Surprises Act," which prohibits surprise medical billing from out-of-network providers, emergency service providers, and air ambulance providers. These provisions generally apply with respect to plan years beginning on or after January 1, 2022.

Specifically, the No Surprises Act:

- Prohibits surprise medical billing from out-of-network providers, emergency service providers and air ambulance providers.
- Prohibits balance billing a participant by an out-of-network provider for services received at an in-network facility, unless the out-of-network provider provides notice to the participant and the participant consents. The consent rules are narrowly drafted and require consent to be given at least 72 hours prior to receiving treatment.
- Requires coverage of emergency services at in-network rates and without prior authorization.
- Prohibits out-of-network air ambulances from charging participants more than the in-network cost-sharing amounts for their services.
- Requires a 30-day open negotiation period for group health plans to settle out-of-network claims with providers, including out-of-network air ambulance claims.

- Establishes an "Independent Dispute Resolution" process (i.e., binding arbitration) ("IDR") for plans and out-of-network providers who cannot agree on a rate during the open negotiation period.

    - Both sides offer a rate and the arbitrator selects one of the two offers based on the market-based median in-network rates and other relevant information. However, the out-of-network provider's actual billed charges and public payer rates are excluded from consideration.

    - No minimum rate that must be at issue to access IDR.

    - Built-in protections to prevent abuse:

        - Plans must make an interim payment to the provider while the rate is being negotiated (though no minimum amount is specified).

        - The party whose rate is ultimately not chosen by the arbitrator is responsible for paying for all fees charged.

        - The party who initiates the IDR is prohibited from initiating another IDR with the same party related to the same item or service for 90 days following the arbitrator's determination.

The No Surprises Act also contains other "patient protections" that are tangentially related to surprise billing, including:

- A requirement that insurance ID cards include in- and out-of-network deductible amounts and maximum out-of-pocket costs.

- A requirement that the Departments issue proposed regulations under the Affordable Care Act's "Provider Nondiscrimination" protections.

- An extension of the Affordable Care Act's external review process to adverse benefit determinations under the surprise billing provisions.

- A requirement that group health plans provide an "Advanced Explanation of Benefits" containing good faith estimates of the costs of services the participant is likely to receive and associated disclaimers.

- A requirement that certain participants receive up to 90 days of continued coverage at in-network cost-sharing rates when their provider moves out-of-network.

- A requirement that group health plans offer price comparison guidance via telephone and an online cost comparison tool.

- The establishment of a grant program to create and improve "State All Payer Claims Databases," under which the Secretary of Labor is required to establish a standardized reporting format for voluntary reporting to such databases by self-insured group health plans.

- A requirement that group health plans provide participants up-to-date provider directories, and participants who rely on incorrect information received will only be liable for in-network cost-sharing amounts.

TRANSPARENCY PROVISIONS

The Act adds several requirements to enhance multiemployer health and welfare plan transparency. These transparency enhancements include:

- **Mental Health Parity Analysis**: Requiring that group health plans conduct comparative analyses of the nonquantitative treatment limitations ("NQTLs") (e.g., medical management standards, formulary design for prescription drugs, fail-first policies or step therapy protocols) used for medical and surgical benefits as compared to mental health and substance use disorder benefits (This was previously recommended, but not required to be compliant with the Mental Health Parity and Addiction Equity Act ("Mental Health Parity Act").
    - Must also be able to provide, if requested by either the DOL, HHS or state insurance regulator (if applicable), a detailed written analysis of such compliance with the Mental Health Parity Act.
    - Requests may start to be made by regulators as soon as February 10, 2021 (45 days after enactment of the Act).
    - Multiemployer plans should start to prepare if not already conducting this analysis and your service providers are likely to assist with this analysis.
    - Departments are required to request comparative analysis from at least 20 plans per year that involve potential violations of the Mental Health Parity Act.
        - If found non-compliant, plans have 45 days to correct compliance issues.
        - If final determination made of noncompliance, required to notify enrollees of noncompliance within 7 days.
    - Departments required to issue guidance within 18 months with at least a 60 day comment period.
- **Prohibition on Gag Clauses**: Prohibiting a group health plan from entering into a services agreement that, directly or indirectly, restricts the group health plan from disclosing provider-specific costs, quality of care information, or electronically accessing de-identified claims data. A group health plan is required to annually report compliance with this requirement.
    - No effective date specified, so likely effective upon enactment of Act (12/27/20).
    - Multiemployer plans should review existing contracts with TPAs and modify as necessary to ensure compliance.
- **Disclosure of Compensation**: Requiring disclosure by health benefit brokers and consultants to plan sponsors regarding at the time of contracting their reasonably expected direct and indirect compensation for referral of services to group health plans. This does not apply to insurance providers or pharmacy benefit managers and only applies if direct or indirect compensation will be more than $1,000.
    - These changes take effect one year after enactment of the Act (12/27/21).

- **Reporting of Benefits and Costs:** Requiring group health plans to annually report on plan medical costs, prescription drug spending, premiums, and any manufacturer rebates received by the plan to the Departments.

    - The first reporting is due one year after enactment of the Act (12/27/21). Each subsequent report would be due by June 1 of each year.

    - Most multiemployer plan sponsors will have their vendors do this reporting.

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MEMORANDUM

TO: Board of Trustees of the Warehouse Employees Local 730 Health and Welfare Fund

FROM: Jim Kimble
Merle DeLancey

DATE: March 26, 2021

SUBJECT: American Rescue Plan Act ("ARPA") Temporary COBRA Subsidy

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On March 11, 2021, President Biden signed into law the American Rescue Plan Act ("ARPA"). The ARPA includes a temporary 100% COBRA premium subsidy for individuals (and their covered dependents) who, presumably due to the pandemic, have suffered an involuntary termination of service or reduction in hours, which has led to a loss or reduction of their group health plan coverage. The subsidy is not available to individuals who voluntarily terminate their employment. The following is a summary of the Act's COBRA premium subsidy provisions.

The COBRA premium subsidy is available from April 1, 2021, through September 30, 2021. However, the subsidy will end prior to September 30, 2021, if the individual's maximum COBRA continuation coverage period expires prior to this date or if the individual becomes eligible for coverage under another group health plan or Medicare. Covered individuals are responsible for notifying the plan of their eligibility for coverage under another group health plan or Medicare. If an individual fails to notify a plan of their eligibility for other coverage (and the failure is not due to reasonable cause), a penalty of $250 will be imposed on such individual. However, if there is an intentional failure to notify a plan of the eligibility for other coverage, the penalty is the greater of $250 or 110% of the premium subsidy amount provided after the loss of eligibility.

In addition to individuals who first become eligible for COBRA on and after April 1, 2021, the subsidy must also be extended to those who were eligible to elect COBRA, but have not yet done so as of April 1, and those who previously elected COBRA coverage, but then discontinued it prior to April 1. These individuals must be provided a special 60-day COBRA election period beginning April 1, 2021 and ending 60 days after their receipt of a special COBRA election notice, explaining their rights under the ARPA. Associated should immediately begin identifying the individuals who will qualify for this relief, so that notification can be made as soon as possible following April 1 (or sooner, if circumstances allow).

In addition to notification of the above special COBRA election period, notice of the availability of the premium subsidy must be included with the plan's COBRA election notice materials. Plans may either amend their current COBRA forms to include the required language or include a separate notice in the COBRA election notice packet. The DOL has been instructed to issue model notices within 30-days of enactment and we recommend using the DOL model notices. Plans will also be required to notify individuals if their COBRA premium subsidy will be ending due to the expiration of the maximum COBRA continuation coverage period (generally, 18 months). This notice will be included with the plan's COBRA expiration notice and model language will be provided by the DOL.

The ARPA provides that the value of the COBRA premium subsidies will be recouped by plan sponsors as a credit against payroll taxes. If the credit exceeds the amount of payroll taxes due (if any), then it will be paid to the plan sponsor as a fully refundable (or advanced) tax credit. It is not yet clear how this will work for multiemployer plans, but additional guidance will be provided by the Treasury to address this issue.

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TO: Board of Trustees of Warehouse Employees Local 730 Health and Welfare Fund

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DATE: March 26, 2021

SUBJECT: COVID-19 Deadline Extensions

In March 2020, DOL's Employee Benefit Security Administration and the Department of Health and Human Services (the "Agencies") suspended certain deadlines related to COBRA, Claims and Appeals, and HIPAA open enrollment. Specifically, effective March 1, 2020, these deadlines were suspended until 60 days after the announced end of the National Emergency due to COVID-19 or such other date announced by the Agencies in a future notification (i.e., the "Outbreak Period"). The statutory provisions under which the deadlines were extended, however, did not appear to permit an extension of these timeframes beyond one year. In EBSA Disaster Relief Notice 2021-01 ("Notice"), the Agencies confirmed that the statutory one-year period could not be extended and provided guidance on how to deal with the deadline extensions.

The Notice provides that the suspended deadlines will be disregarded (or tolled) **until the earlier of (a) one year from the date the plan or individual was first eligible for relief, or (b) the end of the Outbreak Period.** There's an additional clarification (or caveat) that the maximum tolling period will not exceed one year. This interpretation means that each participant or beneficiary has his/her own personal rolling deadline from the date of his/her own event. In other words, the time period each participant or beneficiary has to report an event falling within the Guidance is suspended until the earlier of one year from the date of that event or until the end of the Outbreak Period.

The deadlines that are suspended are:

- HIPAA Special Enrollment Dates
- Date to Elect COBRA Continuation Coverage
- Date to Pay COBRA Premiums
- Date to Notify the Plan of a Qualifying Event that Would Trigger a Beneficiary's Loss of Coverage
- Date to File a Benefit Claim
- Date to File an Appeal of a Claim Denial
- Date to Request External Review of a Claim Denial
- Date to File Additional Information to Perfect External Review Request