Morgan Lewis

MEMORANDUM

TO: Board of Trustees of Bakers Union/FELRA Health and Welfare Fund

FROM: Jim Kimble
Merle DeLancey

DATE: March 10, 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 (Not Applicable to Grandfathered Plans).

- 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.