INDUSTRY AND LOCAL 338 WELFARE FUND AND THE CONSOLIDATED APPROPRIATIONS ACT, 2021 - PRIVATE HEALTH INSURANCE PROVISIONS: NO SURPRISES ACT, TRANSPARENCY, AND PARITY

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OVERVIEW

- These provisions were included in the Consolidated Appropriations Act, 2021 (the "CAA"), the $2.3 trillion spending bill which was signed into law on December 27, 2020.
- Unlike some other benefits-related initiatives of the Trump administration, these requirements have bipartisan support and are not expected to be rescinded.
- The requirements generally become effective on the first day of the Plan Year beginning on or after January 1, 2022. For the Industry and Local 338 Welfare Fund, the effective date for most of the new requirements is **July 1, 2022**.
- The effective date provides a short window for compliance. We cannot predict whether any effective dates will be extended.
- The CAA is viewed as the most comprehensive legislation affecting health plans since the Patient Protection and Affordable Care Act was enacted in 2010.

OVERVIEW

- The new requirements are protective of participants and are intended to (a) relieve them of the high costs of using out-of-network ("OON") providers and (b) help them predict costs in advance. For instance, the No Surprises Act will remove participants from many payment disputes with OON providers, leaving those disputes for final offer, baseball-style arbitration between the Fund and the OON provider.

- Note that New York State was the first state to enact a surprise billing law, which went into effect on March 31, 2015. The New York law has been favorable to providers because arbitrators base determinations on the 80th percentile of provider charges, which are generally many times higher than in-network prices.

- However, as a self-funded plan governed by ERISA, the Welfare Fund is not covered by the State law because ERISA pre-empts state law. In contrast, the federal law applies to both self-funded plans and fully insured plans.

- There are many open questions about these requirements and regulations are forthcoming.

- Although many of the actions required for compliance are the responsibilities of the Fund's medical/hospital and prescription benefit Third-Party Administrators ("TPAs"), the Board of Trustees is responsible for ensuring compliance.

OVERVIEW

- While much of the new responsibilities lie with the TPAs, the Fund will need to focus on the following:
  - Obtaining assurances from the Fund's TPAs regarding their compliance with these new requirements;
  - Service provider contract amendments to reflect these new responsibilities;
  - Website enhancements;
  - SPD updates; and
  - Communication with participants regarding these changes.
- The following slides summarize the CAA.

NO SURPRISES ACT – COVERAGE OF EMERGENCY SERVICES

- Any plan that covers services in a hospital or freestanding emergency department must provide emergency coverage:
  - without a prior authorization requirement; and
  - regardless of whether the provider/facility participates in the plan's network.

NO SURPRISES ACT – COVERAGE OF EMERGENCY SERVICES

- For emergency services provided by an OON provider/facility, the following requirements apply:
  - No prior authorization requirement can be imposed;
  - Can't apply any coverage limitation that is more restrictive than would apply in-network;
  - Participant cost-sharing – i.e., copayments, coinsurance and deductibles – can't be greater than if the services were provided in-network; and
  - Cost-sharing requirement must be calculated as if the total in-network charge were equal to the "recognized amount" (generally the plan's median contracted rate).

NO SURPRISES ACT – PLAN OBLIGATIONS WITH RESPECT TO EMERGENCY SERVICES

- Within 30 days of transmission of bill from OON provider/facility, plan must send an initial payment or a notice of denial.
- Payment must be made directly to OON facility/provider and must be equal to the amount that the OON rate exceeds the cost-sharing amount.
- Cost-sharing amounts by the participant for emergency services count for the in-network deductible and out-of-pocket maximum ("OOPM").

NO SURPRISES ACT – REGULATIONS TO BE ISSUED

- By 7/1/21, the DOL, in consultation with IRS and HHS, must issue rules regarding:
  - The methodology to determine the qualifying payment amount;
  - The information that the plan must share with the OON provider/facility in making its determination;
  - Applicable geographic regions; and
  - Complaint process.

NO SURPRISES ACT – DEFINITION OF "QUALIFYING PAYMENT AMOUNT"

- The No Surprises Act defines "Qualifying Payment Amount" ("QPA") as:
  - For an item or service furnished in 2022, the QPA is the median of the plan's contracted rates as the total maximum payment under the plan on 1/31/19 for the same or similar item/service provided by a provider in the same or similar specialty and provided in the geographic region in which the item/service is furnished, increased by the percentage increase in the consumer price increase ("CPI") over 2019, 2020, and 2021.
  - For items/services furnished in 2023 and subsequent years, the QPA is determined based on the median cost in the previous year increased by the percentage increase in the CPI over the previous year.
  - There is a special rule for newly covered items/services.

NO SURPRISES ACT – DEFINITION OF "RECOGNIZED AMOUNT"

- The "Recognized Amount" ("RA") for items/services provided by OON provider/facility means, with respect to self-funded plans, the QPA, i.e., generally the median contracted rate.

NO SURPRISES ACT – COVERAGE OF NON-EMERGENCY SERVICES BY OON PROVIDERS AT CERTAIN PARTICIPATING FACILITIES

- In addition to protections for emergency services, the No Surprises Act protects participants who receive ***non-emergency services*** at a network facility in cases where the OON provider has not complied with "***notice and consent***" requirements (explained later).
- The inapplicability of these protections for OON providers who comply with the notice and consent requirements do **not** apply to certain types of providers, such as ***anesthesiologists, laboratories and radiologists***.

NO SURPRISES ACT – COVERAGE OF NON-EMERGENCY SERVICES BY OON PROVIDERS AT CERTAIN PARTICIPATING FACILITIES

- The protections include:
  - Plan cannot impose greater cost-sharing than applicable if provider had been in-network;
  - Cost-sharing requirement must be calculated as if the total charges were equal to the Recognized Amount;
  - Plan must send initial payment or notice of denial within 30 days of transmission of bill;
  - Plan must make payment directly to OON provider; and
  - Plan must apply cost-sharing to maximum in-network deductible and OOP maximums.

NO SURPRISES ACT – OTHER PATIENT PROTECTIONS

- Choice of health care professional – if a plan requires a participant to designate a primary care provider ("PCP"), it must permit designation of any available participating PCP.
- If applicable, plan must permit designation of a participating pediatrician as PCP for child.
- Plan may not require authorization or referral for OB/GYN care.
  - Note that the Fund does not have these limitations.

NO SURPRISES ACT – AUDIT PROCESS AND REGULATIONS FOR QUALIFYING PAYMENT AMOUNTS

- By no later than 10/1/21, the IRS, in consultation with DOL and HHS, must establish a process by which plans are audited by the IRS to ensure plans are in compliance with required payment amounts.
- IRS must audit a sample of claims data from not more than 25 group health plans per year beginning with 2022.
- IRS may also conduct plan audits if complaints are received regarding the plan.
- Beginning for 2022, IRS must submit to Congress an annual report on the number of audited plans.

NO SURPRISES ACT – DETERMINING THE OON RATES AND INDEPENDENT DISPUTE RESOLUTION PROCESS ("IDR")

- In the 30-day period beginning when the OON provider/facility receives the plan's initial payment or denial notice, the OON provider/facility or plan may initiate open negotiations to determine an agreed upon amount.
- There is a 30-day negotiation period.
- During the 4-day period beginning on the day after the end of the open negotiation period, the provider/facility or plan may initiate the Independent Dispute Resolution Process ("IDR") by submitting a notice to the other party and the DOL.

NO SURPRISES ACT – IDR

- DOL, along with IRS and HHS, has until 12/27/21 to establish the IDR process.
- The parties may continue negotiations before a determination is issued under the IDR process. If successful, the IDR process shall provide a method to determine payment to the entity selected for the IDR.
- The IDR process shall specify criteria under which multiple qualified items and services may be considered jointly as part of a single determination for efficiency purposes in cases where (a) items/services are rendered by same provider/facility, (b) payment is due by same plan, and (c) the items/services were furnished during 30-day period following date on which the first item/ service was furnished or alternative period determined by DOL for use in limited situations, such as by the parties' consent or in the case of low-volume items/services.
- Items/services included in a bundled payment may be part of a single determination under the IDR process.

NO SURPRISES ACT – CERTIFICATION AND SELECTION OF IDR ENTITIES

- DOL/IRS/HHS must jointly establish a process to certify entities for IDR. The process must ensure that a certified entity:
  - Has (directly or indirectly) sufficient medical, legal, and other expertise and sufficient staffing to make timely determinations;
  - Must not be a plan or insurance issuer or affiliate thereof, or affiliate or subsidiary of a professional or trade association of health plans or health insurance issuers or of providers/facilities;
  - Has appropriate indicators of fiscal integrity; and
  - Maintains confidentiality of individually identifiable health information.

NO SURPRISES ACT – CERTIFICATION AND SELECTION OF IDR ENTITIES

- Certification shall be for a 5-year period.
- Process for revocation of certification for non-compliance.
- Parties shall jointly select IDR entity within 3-business day period following the date of the initiation of IDR.
- If parties fail to make timely selection of IDR entity, DOL shall make the selection within the 6-business day period after the date of initiation of IDR.

NO SURPRISES ACT – RESPONSIBILITIES OF CERTIFIED IDR ENTITIES

- Entity has 30 days from being selected to select either party's offer and notify the parties of its determination.

NO SURPRISES ACT – SUBMISSION OF OFFERS

- Within 10 days after the selection of the certified IDR entity, the parties must each submit an offer for a payment amount and any other requested information.

NO SURPRISES ACT – CONSIDERATIONS IN DETERMINING WHICH OFFER TO ACCEPT

- In selecting an offer, the certified IDR entity shall consider the following:
  - The qualifying payment amount, i.e., generally the median contracted rate for self-funded plans;
  - The level of training, experience, and quality and outcomes measurements of provider/facility;
  - The market share held by the provider/facility or plan/issuer;
  - The acuity of the patient or the complexity of providing the item/service;
  - The teaching status, case mix, and scope of services of the facility;
  - Demonstrations of good faith efforts (or lack thereof) made by the provider/facility or plan to enter into network agreements and contracted rates during the previous 4 plan years.

NO SURPRISES ACT – PROHIBITION ON CONSIDERATIONS IN DETERMINING WHICH OFFER TO ACCEPT

- In selecting an offer, the certified IDR entity must **not** consider the following:
  - Usual and customary charges,
  - Billed charges, or
  - Medicare/Medicaid/CHIP/TRICARE payment rates.

NO SURPRISES ACT – EFFECT OF DETERMINATION BY CERTIFIED IDR ENTITY

- IDR determination is:
  - Binding on the parties, with exceptions for fraud or misrepresentation, and
  - Not subject to judicial review, except (1) where the award was procured by corruption, fraud, or undue means; (2) where there was evident partiality or corruption in the arbitrator; (3) where the arbitrator was guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or (4) where the arbitrator exceeded his/her powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

NO SURPRISES ACT – SUSPENSION OF CERTAIN IDR NOTICES REQUESTS AFTER SUBMISSION OF AN IDR NOTICE

- The party that submits an IDR request may not submit a subsequent request during the 90-day period following the IDR determination involving the same other party for an item/request that was subject to the initial request.
- After this 90-day window, the party may once again initiate the IDR process on the basis of those accrued claims.
- This rule is designed to encourage efficiency in the IDR process by incentivizing parties to bundle similar claims.
- The DOL/IRS/HHS must jointly submit reports to Congress examining the impact of the suspension requirement, including whether it delays payment determinations or impacts early open negotiations and whether any plans have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day suspension period.

NO SURPRISES ACT – COSTS OF IDR

- The party whose offer is not chosen is responsible for all fees charged by IDR entity.
- If settlement is reached, each party may pay half of all fees, unless parties agree otherwise.
- There will also be a fee to be set by the DOL that will be payable to the DOL.

NO SURPRISES ACT – TIMING OF PAYMENT

- Plans have 30 days to make payment after open negotiation or selection of offer.

NO SURPRISES ACT – PUBLICATION OF INFORMATION RELATED TO IDR

- The DOL will have on its website for each calendar quarter beginning in 2022 the following information:
  - The number of IDR notifications submitted in the quarter;
  - The size of the provider practices and the facilities submitting IDR notifications;
  - The number of determinations made;
  - The number of times the payment amount exceeded the QPA, i.e., the median contract rate;
  - The total amount of IDR fees paid and DOL expenditures to carry out the IDR process;
  - A description of the items/services subject to IDR;
  - The geography in which the items/services were provided;
  - The offer amounts expressed as a percentage of the QPA;
  - Which offer was selected and amount of selected offer as a percentage of the QPA;
  - The category and practice specialty of the provider/facility;
  - The identity of the parties;
  - The length of time to make each determination; and
  - The compensation paid to each IDR entity.

NO SURPRISES ACT – PROVIDER REQUIREMENTS: NO BALANCE BILLING FOR EMERGENCY SERVICES

- Facilities/providers are prohibited from billing participants and holding them liable for any amount other than cost-sharing for any emergency services provided beginning in the first plan year beginning on or after 1/1/22 (7/1/22 for the Industry and Local 338 Welfare Fund).

NO SURPRISES ACT – PROVIDER REQUIREMENTS FOR NON-EMERGENCY SERVICES PROVIDED IN A PARTICIPATING HOSPITAL

- Facilities/providers are prohibited from billing participants and holding them liable for any amount other than cost-sharing for any non-emergency services provided at a participating facility beginning in the first plan year beginning on or after 1/1/22 (7/1/22 for the Industry and Local 338 Welfare Fund), subject to the following exception.

NO SURPRISES ACT – PROVIDER REQUIREMENTS FOR NON-EMERGENCY SERVICES PROVIDED IN A PARTICIPATING HOSPITAL – EXCEPTION WHERE OON PROVIDER COMPLIES WITH "NOTICE AND CONSENT" REQUIREMENT

- The balance-billing prohibition for ***non-emergency*** services provided in a participating facility does not apply (with some exceptions discussed later) if the OON provider complies with "Notice and Consent" requirements.

NO SURPRISES ACT – PROVIDER REQUIREMENTS FOR NON-EMERGENCY SERVICES PROVIDED IN A PARTICIPATING HOSPITAL – EXCEPTION WHERE OON PROVIDER COMPLIES WITH "NOTICE AND CONSENT" REQUIREMENT

- The DOL is required to issue guidance on the notice and consent requirements by 7/1/21. The "Notice and Consent" ("N&C") requirements are as follows:
  - OON provider/facility must provide written notice at least 72 hours prior to furnishing the items/services which states that participant has opted to receive services from OON facility/provider and has the choice to seek care from a participating provider/facility;
  - The notice must be available in 15 languages.
  - The participant must consent to the treatment.
  - The provider/facility must provide signed copy of the consent to the participant.

NO SURPRISES ACT – PROVIDER REQUIREMENTS FOR NON-EMERGENCY SERVICES PROVIDED IN A PARTICIPATING HOSPITAL – EXCEPTION WHERE OON PROVIDER COMPLIES WITH "NOTICE AND CONSENT" REQUIREMENT

- The N&C must include the following information:
  - The provider's/facility's OON status;
  - The good faith estimated amount of charges, and notice that the estimate or consent is not a contract for the estimated amount;
  - If the facility is in-network and the provider is OON, the notice shall include a list of in-network providers who can perform the services;
  - Information regarding any applicable prior authorization or other care management limitations.

NO SURPRISES ACT – PROVIDER REQUIREMENTS FOR NON-EMERGENCY SERVICES PROVIDED IN A PARTICIPATING HOSPITAL – EXCEPTION WHERE OON PROVIDER COMPLIES WITH "NOTICE AND CONSENT" REQUIREMENT

- Requirements of Consent:
  - Consent must be signed by participant *before* the item/service is provided;
  - It must acknowledge that participant has received the notice and has been informed that charges may not count for meeting in-network deductible or other limitation;
  - It must show the date that the notice was provided and that the consent was signed; and
  - Provider/facility must retain consent for 7 years.

NO SURPRISES ACT – PROVIDER REQUIREMENTS FOR NON-EMERGENCY SERVICES PROVIDED IN A PARTICIPATING HOSPITAL – EXCEPTION TO THE "NOTICE AND CONSENT" EXCEPTION

- The exception to the balance-billing prohibition for non-emergency services provided in a participating facility does not apply to "ancillary services" or if the item/service is furnished due to unforeseen, urgent medical needs that arise when the item/service is provided.
- This means that there is no exception to the balance billing prohibition for these services.
- Ancillary services is defined as:
  - Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology,
  - Diagnostic services (including radiology and laboratory services),
  - Items/services provided by other specialty practitioners determined by the DOL through rulemaking, and
  - Items/services provided by an OON provider if there is no in-network provider who can furnish such item/service at the facility.

NO SURPRISES ACT – PROVIDER NOTICE REQUIREMENTS

- Provider/facility must make publicly available and (if applicable) post on website and provide participants a one-page notice with:
  - information regarding the balance billing prohibitions of the No Surprises Act and any other State law requirements regarding the amount of charges, and
  - information to contact Federal/State agencies regarding violations.

NO SURPRISES ACT – ENFORCEMENT

- DOL may impose fine on provider/facility of up to $10,000 per violation, with exemptions for hardship cases.
- Penalties may be waived in certain circumstances if facility/provider withdraws the unlawful bill within 30 days of the violation and provides reimbursement (with interest) if an impermissible amount was paid.
- DOL shall establish a consumer complaint process by 1/1/22.

NO SURPRISES ACT – ENDING SURPRISE AIR AMBULANCE BILLS

- For air ambulance services from an OON provider, the following requirements apply:
  - Participant cost-sharing can't be greater than if services were provided in-network and must be based on rates that would apply if services were provided by an in-network provider;
  - Cost-sharing amounts count for the in-network deductible and OOPM.

NO SURPRISES ACT – ENDING SURPRISE AIR AMBULANCE BILLS

- For air ambulance services from an OON provider, the following requirements apply:
  - Within 30 days of transmission of bill from OON provider, plan must send an initial payment or notice of denial.
  - Payment must be made directly to OON provider and must be equal to the amount that the OON rate exceeds the cost-sharing amount.
  - Same negotiation and IDR process for OON air ambulance services as apply to other emergency services, with some additional considerations for IDR entity to consider, such as the ambulance vehicle type and the population of the pick-up location.

NO SURPRISES ACT – ENDING SURPRISE AIR AMBULANCE BILLS: REPORTING REQUIREMENTS FOR AIR AMBULANCE PROVIDERS

- Air ambulance providers will have to report certain information to DOL, including cost data, number and location of provider's bases, number and type of aircraft, number of claim denials, etc.

NO SURPRISES ACT – ENDING SURPRISE AIR AMBULANCE BILLS: REPORTING REQUIREMENTS FOR HEALTH PLANS

- By no later than the 90th day after the last day of the calendar quarter after the DOL issues a final rule, and subsequently thereafter, health plans will need to report the following information to the DOL:
  - Air ambulance claims data, including whether services were furnished on emergent/nom-emergent basis, whether provider is part of a hospital-owned or sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska, whether transport originated in rural or urban area, type of aircraft.

NO SURPRISES ACT – ENDING SURPRISE AIR AMBULANCE BILLS: PUBLICATION OF COMPREHENSIVE REPORT

- HHS, in consultation with Department of Transportation, shall publish a report on air ambulance services, including, but not limited to, information about the extent of competition among air ambulance providers and an assessment of whether there are instances of unfair, deceptive or predatory practices by air ambulance providers.

NO SURPRISES ACT – ENDING SURPRISE AIR AMBULANCE BILLS: ADVISORY COMMITTEE

- Advisory committee on air ambulance quality and patient safety to be established.
- The law also establishes an advisory committee on ground ambulance and patient billing.

TRANSPARENCY FOR OON DEDUCTIBLES AND OOP LIMITATIONS – ID CARDS

- Effective 7/1/22 for the Fund, participant ID cards must state in clear writing:
  - Deductible
  - OOPM
  - Tel # and web address for consumer assistance information, such as information for in-network hospitals and urgent care facilities

PROTECTIONS AGAINST PROVIDER DISCRIMINATION

- The CAA directs HHS/DOL/IRS to issue regulations to implement a provision of the ACA that prohibited discrimination against “any willing provider” by 7/1/22.

GOVERNMENT REPORTS

- The CAA sets various due dates for government agencies to issue reports on the effects of these new requirements, adequacy of provider networks, and IDR.

EXTERNAL REVIEW

- The Fund must establish an external review process to determine whether it correctly determined surprise medical billing protections do not apply.

REQUIREMENT TO PROVIDE FAIR AND HONEST ADVANCE COST ESTIMATE – ADVANCED EXPLANATION OF BENEFITS ("EOB")

- Beginning on 7/1/22, the Fund must, upon request by a provider/facility or authorized representative of participant, provide a notice – an advance EOB - with the following information:
  - **Whether the provider/facility is in-network or OON;**
  - **If the provider/facility is in-network, the contracted rate for the service;**
  - **If the provider/facility is OON, a description of how to obtain information on participating providers;**
  - **The good faith cost estimate from the provider/facility;**
  - **The good faith estimate of the amount the plan is responsible for paying;**
  - **The good faith estimate of the participant's cost-sharing amount;**
  - **The good faith estimate of the amount the participant has incurred toward meeting plan limits (deductible, OOPM);**
  - **If applicable, a disclaimer regarding medical management requirements, such as concurrent review, prior authorization, step-therapy, fail-first protocols;**
  - **A disclaimer that the information is only an estimate and subject to change; and**
  - **Any other information or disclaimer deemed appropriate by plan.**
- The advance EOB is generally due at least 3 business days before the service is to be furnished, and by no later than 1 business day after the date of the scheduling of the service. There may be modified timing requirements for items/services that have low utilization or significant variation in costs.

PROVIDER OBLIGATIONS TO PROVIDE INFORMATION UPON REQUEST AND FOR SCHEDULED APPOINTMENTS

- Beginning on 1/1/22, providers must, within certain time periods,
  - **Ask whether the individual is enrolled in a plan, and**
  - **Notify the plan of the good faith estimate of the expected charges for the item/service.**

PATIENT-PROVIDER DISPUTE RESOLUTION

- By no later than 1/1/22, the government must establish a patient-provider dispute resolution process for uninsured individuals.

CONTINUITY OF CARE

- Effective 7/1/22, the Fund has new obligations for "continuing care patients."
- Specifically, the Fund must provide 90 days of continued in-network coverage to the participant if his/her treating provider leaves the network (or 90 days from the date that the participant is no longer a continuing care patient, whichever is earlier).
- The Fund must notify participants of the termination of the provider's in-network status and provide participants an opportunity to notify the plan of the participant's need for transitional care
- This requirement does not apply to for-cause terminations of a provider for failure to meet quality standards or for fraud.
- The CAA defines a "continuing care patient" as a person who is:
  - undergoing a course of treatment for a "serious and complex condition" from the provider or facility;
  - undergoing a course of institutional or inpatient care from the provider or facility;
  - scheduled to undergo nonelective surgery from the provider;
  - pregnant and undergoing a course of treatment for pregnancy from the provider; or
  - determined to be terminally ill and is receiving treatment for such illness from the provider or facility.
- The CAA defines serious and complex condition as (a) in the case of an acute illness, a condition serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm, or (b) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.
- Such providers must continue to accept payment from participant at in-network levels and adhere to the Fund's rules, but the Fund's payment will be based on OON rates.

PRICE COMPARISON TOOL

- Effective 7/1/22, the Fund must offer price comparison guidance by phone and also make available on the Fund's website a price comparison tool that allows a participant to compare the amount of cost-sharing that he/she would be responsible for paying with respect to a specific item or service — factoring in Plan year, geographic region and participating providers.

ACCURACY OF PROVIDER DIRECTORIES

- Effective 7/1/22, the Fund must ensure that its in-network directories are up-to-date and that participants can access the directory online or by phone.
- The Fund must have a process for verifying the accuracy of the directory at least every 90 days and have a procedure in place for removing a provider or facility if the Fund is unable to verify the provider or facility's information.
- If a participant requests information via phone or electronically regarding whether a provider is in-network, the Fund must respond in writing (or electronically) within one business day (and this communication must be maintained in the individual's file for at least 2 years).
- The Fund must have a database on its website with a list of each provider and facility that has a direct or indirect contractual relationship with the Fund; and directory information (name, address, specialty, phone number and digital contact information for the provider).
- A participant who relies on any inaccurate provider directory information will be responsible for only the in-network cost-sharing amount.
- There are additional requirements on providers/facilities regarding directory information.

DISCLOSURE ON PATIENT PROTECTIONS AGAINST BALANCE BILLING

- Effective 7/1/22, the Fund must make available on its website and on EOBs information regarding balance-billing protections.
- Such information must include the appropriate federal and state contact information for participants to report any violations.

TRANSPARENCY – DISCLOSURE OF DIRECT AND INDIRECT COMPENSATION TO CONSULTANTS AND BROKERS

- These new requirements apply to contracts where the service provider reasonably expects to receive $1,000 or more in compensation (direct or indirect) for the services.
- Consultants and brokers must disclose whether they will provide fiduciary services, and the direct and indirect compensation received related to the Fund.
- This information must be disclosed to the Trustees before the contract is entered into, extended or renewed.
- The Trustees must be notified of any change to the required disclosures no later than 60 days from the date that the service provider is informed of the change.
- This requirement applies to contracts that are executed or renewed on and after 12/27/21.

TRANSPARENCY IN COVERAGE FINAL RULE ISSUED ON OCTOBER 29, 2020

- In addition to the Transparency requirements of the CAA, the Fund has to comply with additional requirements included in a separate rule that was issued on 10/29/20.
- Effective 7/1/23, the Fund will be required to make available to participants personalized out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services, including prescription drugs, through an internet-based self-service tool and in paper form upon request.
- This tool is intended to permit participants to get real-time and accurate estimates of their cost-sharing liability for health care items and services from different providers.
- An initial list of 500 shoppable services as determined by the government will be required to be available via the internet based self-service tool beginning on 7/1/23.
- The remainder of all items and services will be required for these self-service tools beginning on 7/1/24.

TRANSPARENCY IN COVERAGE FINAL RULE ISSUED ON OCTOBER 29, 2020

- Effective 7/1/22, the Fund will be required to publicly post the following machine-readable files:
  - In-Network File, showing all applicable rates (negotiated rates and fee schedules) with in-network providers,
  - OON Allowed Amount File, showing historical allowed amounts for covered items and services provided by OON providers, and
  - Prescription Drug File, showing negotiated rates and historical net prices for prescription drugs furnished by in-network providers.
- The above information must be updated monthly and made publicly available on the Fund's website free of charge.
- Participants must be able to access the files without having to log-in.

PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

- The Fund must perform and document a detailed comparative analysis of its nonquantitative treatment limitations ("NQTLs") applicable to medical/surgical benefits versus those applicable to mental health/substance abuse benefits.
- Examples of NQTLs are:
  - Medical management standards based on medical necessity or appropriateness or whether a treatment is experimental or investigative;
  - Limitations with respect to prescription drug formulary design; or
  - Use of fail-first or step therapy protocols
- Such analysis must be made available to the DOL upon request beginning on 2/10/21.

PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

- The CAA details what must be contained in the comparative analysis. Some examples include:
  - The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical/surgical benefits,
  - The evidentiary standards used for such NQTLs, and
  - The comparative analysis showing that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health/substance use disorder benefits, as written and in operation, are comparable to and are applied no more stringently than those applied to medical/surgical benefits.
- If the DOL reviews the comparative analysis and determines that the Fund is not in compliance, the Fund must specify the actions it will take to be in compliance and, within 45 days, provide a new comparative analysis that demonstrates compliance.
- Following the 45-day corrective action period, if the DOL makes a final determination that the Fund is not in compliance, then not later than 7 days after such determination, the DOL shall notify all participants that the Fund is not in compliance.
- Additional guidance is forthcoming.

REPORTING ON PHARMACY BENEFITS AND DRUG COSTS

- **Beginning on 12/27/21, and 6/1 of each year thereafter, the Fund must submit to HHS/DOL/IRS the following information for the prior plan year:**

1. the beginning and end dates of the plan year;
2. the number of participants and beneficiaries,
3. each state in which the plan is offered;
4. the 50 brand prescription drugs most frequently dispensed, and the total number of paid claims for those drugs;
5. the 50 most costly prescription drugs by annual spend, and the annual spend amount for those drugs;
6. the 50 prescription drugs with the greatest increase in plan expenditures;
7. information about the total spending on health care services;
8. the average monthly premium paid by employers and participants;
9. the impact on premiums of rebates, coupons, other similar renumeration paid by drug manufacturers to the Fund; and
10. any reduction in premiums and OOP costs associated with rebates, fees or other remuneration described in #9.