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EMPLOYEE BENEFITS LAW UPDATE: A YEAR IN REVIEW

SECURE WITH NO SURPRISES: HOT TOPICS IN HEALTH AND PENSION LEGISLATION / REGULATION

March 16 / 1:00 pm Eastern

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EMPLOYEE BENEFITS SUMMER UPDATE
(6-Part Webinar Series / June 1, 8, 15)

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The Panel

Denise M. Clark, *Clark Law Group, PLLC*

Al Holifield, *Holifield & Janich, PLLC*

Kendra Kosko Isaacson, *Pensions Policy Director and Senior Tax Counsel, Senate Committee on Health, Education, Labor & Pensions For Senator Patty Murray, Chair*

Deva Kyle, *Cohen Weiss and Simon LLP*

Zoe Moskowitz, *Schwartz, Steinsapir, Dohrmann & Sommers LLP*

Mary Ellen Signorille, *Moderator*

RETIREMENT ISSUES

- EPCRS
- DOL Missing Participants
- American Rescue Plan Act (ARPA) of 2021

Employee Plans Compliance Resolution System (EPCRS) -- Overpayment Corrections

- Revenue Procedure 2021-30
- Installment payments now allowed in addition to lump sum payments:
  - An affected participant (cannot be a disqualified individual) may correct an overpayment by repaying excess amount in installments.
- Two new methods that provide greater flexibility for defined benefit overpayments:
  - funding exception correction method; and
  - contribution credit correction method.

EPCRS -- Funding Exception Correction Method

- Does not require repayment of the excess amount if the plan meets certain funding requirements.
- If the plan is subject to IRC Section 436, the plan meets the funding requirement if its certified or presumed AFTAP is at least 100%.
- If multiemployer plan, the plan can use this correction method if its funding certification is not critical, critical and declining or endangered status.

EPCRS -- Contribution Credit Correction Method

- Overpayment amount is offset by increase funding.
- The amount of the corrective payment due to the plan is reduced by the incremental increase in the plan's minimum funding standard that is attributable to the overpayment.

EPCRS – Other

- *de minimis* failure threshold raised to $250
- Elimination of anonymous submission option
- Extends self-correction period
- Self-correction by plan amendment - eliminates requirement that increase apply to all eligible employees
- All Audit CAP sanctions to be paid through Pay.gov website.
- Revives the safe harbor correction method, set to expire December 31, 2023.

DOL Guidance on Missing Participants

- DOL issues guidance on missing participants:
  - Best Practices for Pension Plans
  - Compliance Assistance Release 2021-01
  - Field Assistance Bulletin 2021-01(PBGC Missing Participants Program)

DOL Guidance on Missing Participants

- Best Practices for Pension Plans
  - This DOL guidance outlines the best practices defined benefit and defined contributions plans should establish for finding missing participants to ensure such participants receive their retirement benefits timely.

DOL Guidance on Missing Participants

- Compliance Assistance Release 2021-01
  - The DOL publicized an internal memorandum regarding EBSA's Terminated Vested Participants enforcement project. The DOL memorandum describes the EBSA's enforcement program, including the basis for opening investigations, the type of information and documents investigators generally request from plan sponsors, and the systemic issues they look for in their audits.

DOL Guidance on Missing Participants

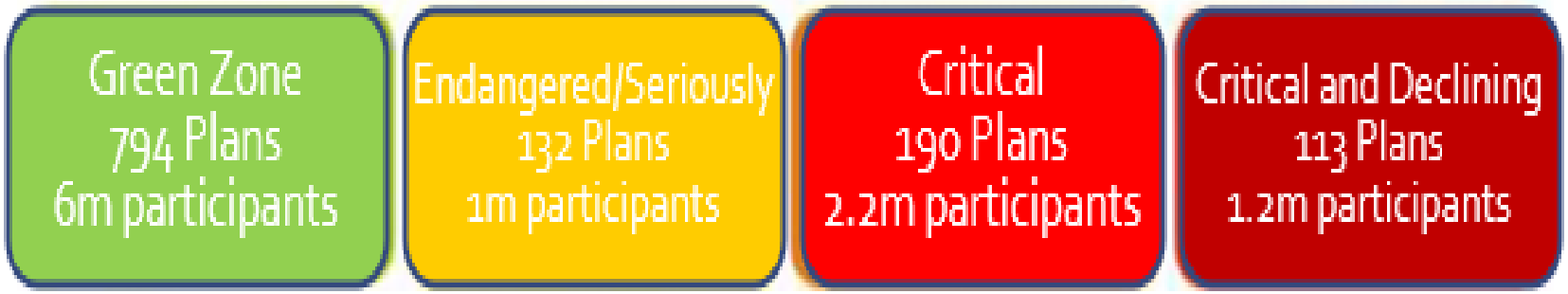
- Field Assistance Bulletin 2021-01 (PBGC Missing Participants Program)
  - The DOL's temporary enforcement policy on terminating defined contribution plans' use of the PBGC Missing Participants Program. The temporary enforcement policy applies to fiduciaries of terminating defined contribution plans and qualified termination administrators (QTAs) of abandoned individual account plans.

American Rescue Plan Act (ARPA) of 2021
Employee Benefits Provisions -- Overview

- Multiemployer Crisis
- American Rescue Plan Act and Special Financial Assistance
- PBGC's Interim Final Rule
- SFA Applications
- Issues still TBD
  - Withdrawal Liability
  - Investment Return Assumptions
  - Other Issues

ARPA -- Background on Multiemployer Pension Plans

- A multiemployer pension plan is a collectively bargained plan that includes two or more employers and one or more labor unions.
- Multiemployer pension plans promise benefits to just under 11 million workers and retirees across 1,300 plans.
- Most multiemployer plans (60%) are generally considered financially healthy but about 10% are troubled, 30% are critically underfunded, and half of those that are critically underfunded (15% of the whole) are projected to be insolvent in the next 20 years (also called critical and declining).
- Many contributing employers, contribute to both declining and healthy plans potentially leading to a cascading effect.



Source: Congressional Research Service, "Data on Multiemployer Defined Benefit (DB) Pension Plans updated May 22, 2020

Legislative Solutions Prior To ARPA

Bills Enacted

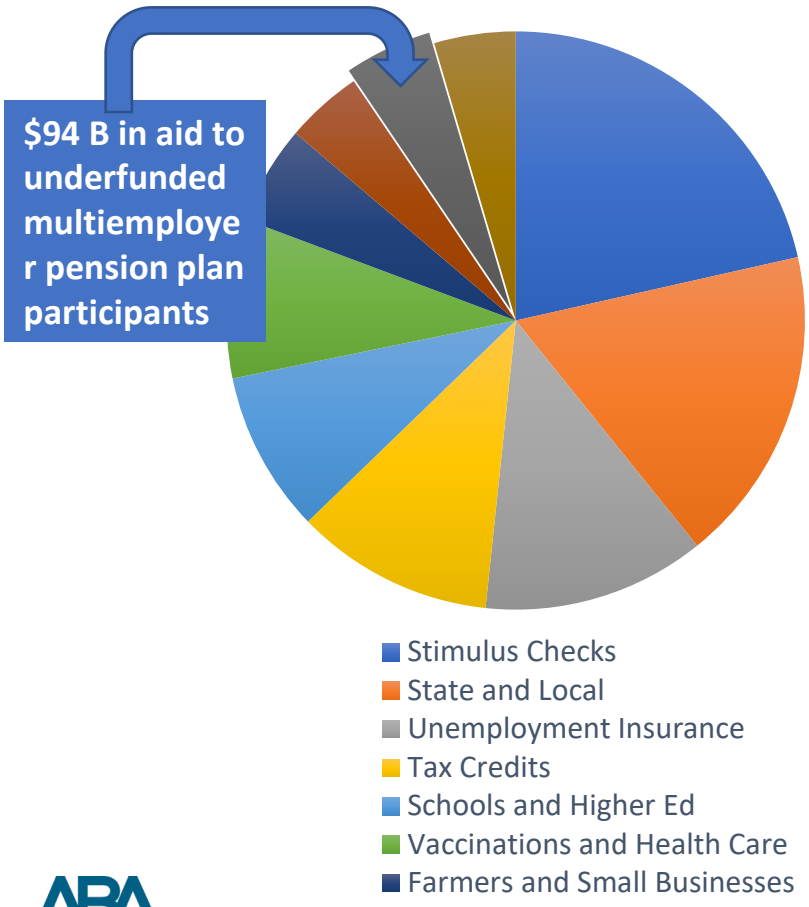
- Pension Protection Act of 2006 (PPA)
- Multiemployer Pension Reform Act of 2014 (MPRA)
- Bipartisan American Miners Act of 2019

Bills Introduced 2017-2021

- Rehabilitation for Multiemployer Pensions Act aka Butch Lewis
- Multiemployer Pension Recapitalization & Reform Plan or "Grassley/Alexander"
- Joint Select Committee on Solvency of Multiemployer Pension Plans
- Chris Allen Multiemployer Pension Recapitalization and Reform Act of 2020 (CAMPRRA)
- Emergency Pension Plan Relief Act of 2021 (EPPRA)

ARPA – Signed into law on March 11, 2021

$1.9 T Stimulus Package



ARPA includes:

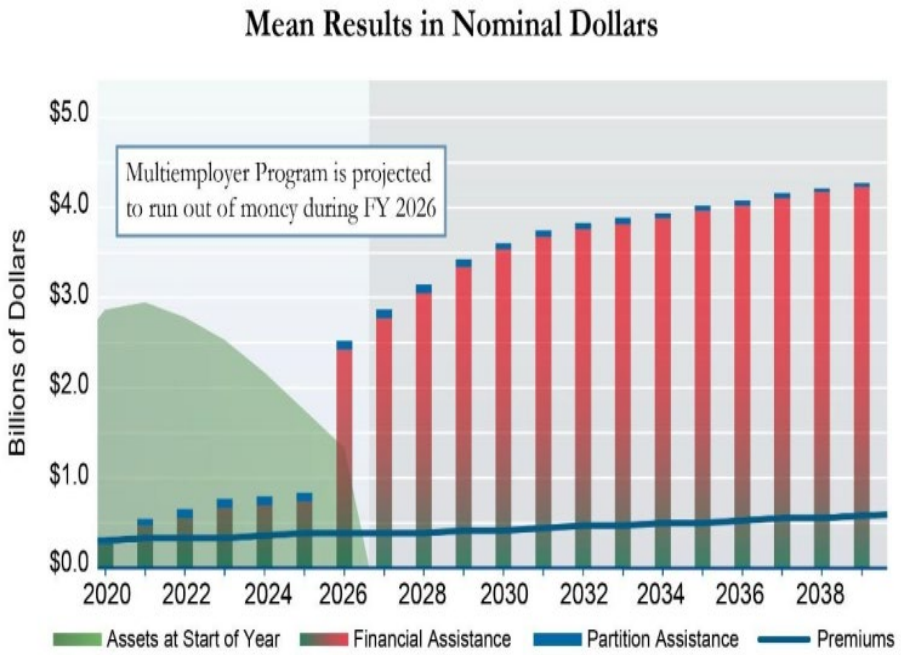
- Temporary Extension of Funding Improvement/Rehabilitation Periods
- Change to Funding Standard Account Rules
- Temporary Delay in Designation of MEPP as in Endangered, Critical, or Critical and Declining Status
- **NEW special financial assistance program ("SFA") to provide direct financial assistance to troubled multiemployer pension plans.**

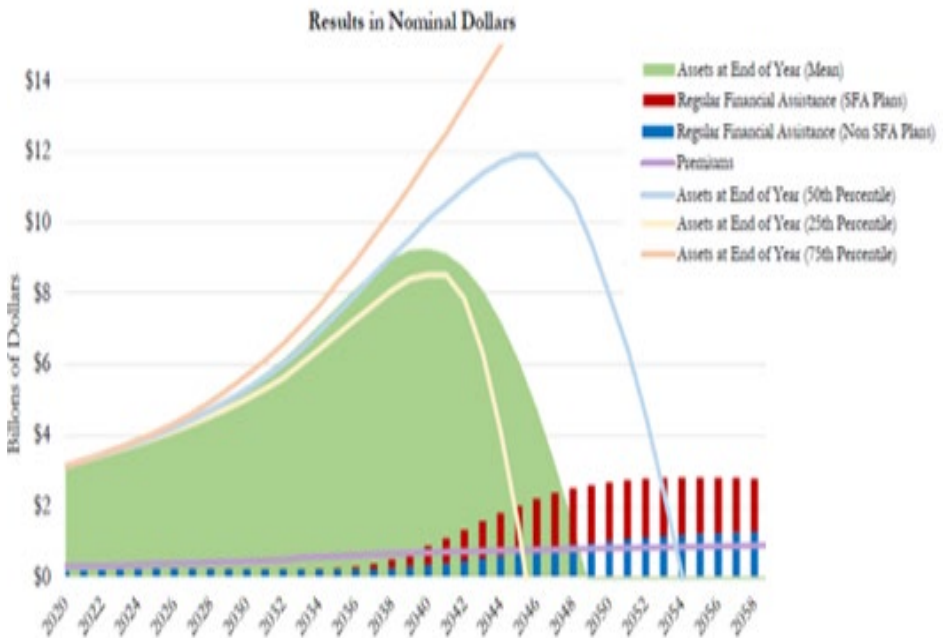
PBGC Criteria Under Interim Final Rule

Eligibility Criteria	• Critical and declining • Suspended benefits under MPRA • Some other critically underfunded plans • Recently insolvent plans
Amount	• Enough for plans to be able to pay benefits though 2051 • Based on an assumed interest rate of 5.5% • Taking into consideration all current and projected future plan resources including contributions, withdrawal liability, and investment returns
Restrictions	• SFA funds invested in investment-grade bonds (2-3% rate) • No: benefit increases, employer contribution reductions, • Must calculate withdrawal liability using mass withdrawal rates • No suspension of benefits under MPRA • Additional reporting and audits

PBGC Funding Improvements

Prior to ARPA's passage, PBGC was facing insolvency in 2026. After ARPA, PBGC projects that it will survive, on average, to 2049. In 25% of their scenarios, PBGC will survive indefinitely.





Source: PBGC FY 2019 Projections Report, PBGC FY 2020 Projections Report

PBGC Estimate of Application Timing

Priority Group	Plan Description	Application Period Begins	Estimated Number of Plans	Actual Number of Plans (Posted by PBGC; Last visited 03/05/2022)
1	Already insolvent or projected to become insolvent before 3/11/2022	7/9/2021	25	23 (18 under review, 5 approved)
2	Implemented MPRA benefit suspensions before 3/11/202 or expected to be insolvency within one year of the date application was filed	1/1/2022	18	7 (4 MPRA, 3 Insolvency, all under review)
3	Critical and declining status plans with greater than 350,000 participants	4/1/2022	1	N/A
4	Projected to become insolvent before 3/11/2023	7/1/2022	3	N/A
5	Projected to become insolvent before 3/11/2026	2/11/2023	22	N/A
6	Present value of Financial Assistance in excess of $1 billion	2/11/2023	11	N/A

PBGC estimates 200+ plans could be eligible but only 80 plans will apply. So far, significantly fewer plans in priority group 2 have applied.

SFA Current Applications

APPROVED

Name of Plan	Date of Application	SFA Amount Requested in Application ($)	SFA Amount Approved ($)	# of Plan Participants	Date of Approval	Date SFA Paid
Road Carriers Local 707 Pension Plan	11/12/2021	710,402,487	812,259,661	3,804	1/19/2022	2/17/2022
Local 138 Pension Trust Fund	8/23/2021	110,212,179	112,601,995	1,752	12/21/2021	1/14/2022
Local 408 International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America Pension Plan	9/27/2021	97,988,851	100,487,608	1,058	1/24/2022	2/18/2022
Bricklayers and Allied Craftworkers Local 5 New York Retirement Fund Pension Plan	9/23/2021	59,880,146	61,757,292	821	1/18/2022	2/14/2022
Idaho Signatory Employers-Laborers Pension Plan	9/1/2021	13,463,736	13,882,183	682	12/23/2021	

- PBGC has rejected 0 applications, approved 5, and 27 applications are currently under review
- 17 applications have been resubmitted with only one approved after resubmit (the rest are under review)
- In every instance of approval, PBGC has approved more than what was requested in the application

SFA Points of Contention

WITHDRAWAL LIABILITY

INVESTMENT RETURN ASSUMPTIONS

OTHER ISSUES:

MPRA APPLICANTS

Withdrawal Liability

- **Generally:** Under 29 U.S.C. §§ 1391 & 1393, withdrawal liability is calculated using a multiemployer plan's UVBs projected with actuarial assumptions and methods "which, in the aggregate, are reasonable …and which, in combination, offer the actuary's best estimate of anticipated experience under the plan." (29 U.S.C. §1393)
- **UNDER ARPA**: PBGC limits withdrawal liability interest rate assumption to PBGC's mass withdrawal rates. (29 CFR § 4262.16)
- **NOTE:** Issue may become less important as: "PBGC intends to propose a separate rule of general applicability under § 4213(a) of ERISA to prescribe actuarial assumptions which may be used by a plan actuary in determining an employer's withdrawal liability."

Investment Return Assumption

Three different sources for understanding the amount of SFA.

- 4262(e)(2)— directs plans to cap their interest rate assumption to, at most, about 5.5% (third segment corporate bond rate plus 2).
- 4262(j)(1)— the amount of financial assistance provided must "be such amount required for the plan to pay all benefits due during the period beginning on the date of payment of the special financial assistance payment under this section and ending on the last day of the plan year ending in 2051, with no reduction in a participant's or beneficiary's accrued benefit as of the date of enactment."
- 4262(l) — restricts SFA assets to "be invested by plans in investment-grade bonds or other investments as permitted by the corporation."
    - In its interim final rule, PBGC declined to permit plans to invest in anything other than investment-grade bonds.

Other Issues

MPRA Applicants:

- **SFA** is open to plans who have received "a suspension of benefits has been approved with respect to the plan under section 305(e)(9) as of the date of the enactment of this section" but limits assistance to solvency through 2051.
- **Under MPRA**, plans must show that "the plan is projected to avoid insolvency" which has been interpreted by the Treasury department to mean solvency through at least a 30-year period where at the end of the period the plan is either still fully funded or the plan's assets are level or increasing.

What's to come?

Changes in funding rules?

Alternative plan designs?

Increase to the PBGC Guarantee?

What's next in Congress?

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HEALTH ISSUES

- **Mental Health Parity & Addiction Equity Act**
- **DOL Investigations**
- **No Surprises Act**

Mental Health Parity & Addiction Equity Act

- The Mental Health Parity and Addition Equity Act (MHPAEA), was originally passed in 2008 with the goal that health plans fairly cover mental health and substance use disorders.
- The Department of Labor has been developing and issuing guidance designed to ensure congruence for both quantitative and non-quantitative treatment limitations.
- The goal is parity both in financial requirements and plan administration.

Mental Health Parity & Addiction Equity Act

- In December of 2020 Congress passed into law the Consolidated Appropriations Act.
- This Bill addresses how the DOL, HHS and IRS will assess how well employer plan sponsors and Health Insurance Carriers are keeping up with the compliance requirements under MHPAEA.

Mental Health Parity & Addiction Equity Act

- Plan sponsors must complete extensive analysis regarding the broad plan limits, Quantitative Treatment Limitations (QTLs) and Non-Quantitative Treatment Limitations (NQTLs) of their plans.
- Part of the compliance requirements are that each plan sponsor complete an analysis of its plan, both written and in operation. This comparative analysis requires plan sponsors to "show your work" in a very detailed fashion.

Mental Health Parity & Addiction Equity Act

- The analysis must be performed on all vendors offering services under your plan.
- This would include your TPA, PBM, networks, utilization review vendors any other vendor who potentially could play a role in treatment limitations for mental health and substance use disorder benefits.

Mental Health Parity & Addiction Equity Act

- This analysis then must be made available both to plan members upon request and the DOL.
- The DOL is looking for three broad areas of documentation:
  - Broad Plan Treatment Limitations
  - Quantitative Treatment Limitations
  - Non-Quantitative Treatment Limitations

Mental Health Parity & Addiction Equity Act

- **Quantitative Treatment Limitations (QTLS)– can be measured numerically.**
- Parity must be determined and documented in six classifications:
  - Inpatient (in-network)
  - Inpatient (out of network)
  - Outpatient (in-network)
  - Outpatient (out of network)
  - Emergency Care
  - Prescription Drugs

Mental Health Parity & Addiction Equity Act

- **Non-Quantitative Treatment Limitations (NQTLS) cannot be measured numerically**.
- NQTLS are processes, strategies, evidentiary standards, or other criteria that limit the scope or duration of benefits for services provided under the plan.

Mental Health Parity & Addiction Equity Act

Examples of NQTLs include:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative
- Formulary design for prescription drugs
- Standards for provider admission to participate in a network, including reimbursement rates
- Plan methods for determining usual, customary, and reasonable charges

Mental Health Parity & Addiction Equity Act

- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (i.e., fail-first policies or step-therapy protocols)
- Exclusions based on failure to complete a course of treatment
- Network tier design, for plans with multiple network tiers (such as preferred providers and participating providers)
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan

Mental Health Parity & Addiction Equity Act

- The DOL requires that the comparative analysis (both in writing and in operation) must demonstrate that the processes, strategies and evidentiary standards and factors are comparable and no more stringent than those applied to medical and surgical benefits.
- To assist with the analysis, DOL has established a Self-Compliance Tool—https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

Mental Health Parity & Addiction Equity Act

- DOL Enforcement Under The Consolidated Appropriations Act, 2021 (CAA).
  - https://www.cms.gov/files/document/2022-mhpaea-report-congress.pdf

DOL Investigations

The following practices and procedures should be avoided when responding to requests for comparative analyses because the Department deems them insufficient:

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations

DOL Investigations

3. Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis
4. Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice
5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

The No Surprises Act

Introduction

1. No Surprise Billing
2. ID Cards
3. Prohibition on Gag Clauses
4. Accuracy of Provider Directories
5. Continuity of Care
6. Good Faith Estimates
7. Advanced EOBs
8. Price Comparison Tool
9. Air Ambulance Reporting
10. Reporting on Pharmacy Benefits and Drug Costs
11. Transparency Final Rule

Introduction

The No Surprises Act was signed into law on December 27, 2020, as part of the Consolidated Appropriations Act, 2021 ("CAA"). The CAA also contains "Transparency" provisions. These changes amend ERISA, the Public Health Service Act, and the Internal Revenue Code.

These new requirements of the CAA are intended to protect consumers against excessive cost sharing and surprise billing by out-of-network providers, to limit the amount that these providers can collect from plans and insurers, and to increase price transparency and constitute the most comprehensive and significant expansion to patient protections since the Affordable Care Act.

Note that, in addition to the Transparency provisions of the CAA, a separate "Transparency Final Rule" was also issued on November 12, 2020.

- These new requirements under the CAA generally apply to all group health plans (both fully-insured and self-insured), including grandfathered health plans, and insurers. However, they generally do not apply to excepted benefits, retiree-only plans, health reimbursement arrangements, and short-term, limited-duration insurance. *Note that the separate "Transparency Final Rule," however, does not apply to grandfathered health plans.*

No Surprise Billing – Covered Services

The No Surprises Act ("NSA") is designed to protect patients from excessive cost-sharing and surprise bills from nonparticipating ("OON") providers in three settings:

- Emergency Services provided by OON providers.
- Non-Emergency Services provided by OON providers at a participating health care facility (if the provider has not satisfied the notice and consent criteria).
- Air Ambulance Services provided by OON providers.

No Surprise Billing – Important Definitions

Emergency Services:

With respect to an Emergency Medical Condition, Emergency Services means an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, along with such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

Emergency Services also includes services otherwise covered by the Plan that are furnished by an OON Provider or a Nonparticipating Emergency Facility (regardless of the department of the Hospital in which such items or services are furnished) **after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which initial services were provided for an Emergency Medical Condition,** unless (1) the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available Network Provider or Facility within a reasonable travel distance (as determined by the attending emergency Physician or treating Health Care Professional), (2) the patient or the patient's authorized representative gives the Out-Of-Network Provider informed written consent to give up cost sharing and Balance Billing protections for these services, and (3) the Provider or Facility satisfies any additional requirements or prohibitions of the No Surprises Act or regulations issued thereunder.

See Code § 9816(a)(3)(C), ERISA § 716(a)(3)(C), and PHSA § 2799A–1(a)(3)(C), as added by section 102 of the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act 2021; see also Treas. Reg. § 54.9816–4T(c)(2).

No Surprise Billing – Important Definitions

Qualifying Payment Amount:

The Qualifying Payment Amount (QPA) is generally the median of the contracted rate for the same or similar item or service covered under the plan as of January 31, 2019, increased to reflect the percentage increase in CPI.

See Treas. Reg. § 54.9816-6T(a)(16); IRS Rev. Proc. 2022-11.

No Surprise Billing – Requirements

(a) In-Network Cost Sharing Applies. For the three categories of services subject to NSB protections:

- The participant's cost sharing requirement cannot be greater than it would be if the services were provided by a participating provider or facility (i.e., participants cannot be required to pay more than their in-network cost sharing requirements - copays, coinsurance, deductibles);
- The plan must count any cost sharing payment towards the in-network deductible and in-network out-of-pocket maximum in the same manner as if the services were received from a participating provider or facility (and must apply such in-network deductible or OOP maximum to such services); and
- The participant generally cannot be balance billed by the OON provider.

(b) Additional Requirements Pertaining to Emergency Services. If a group health plan covers any services in an emergency department of a hospital or in an independent freestanding emergency department, the plan must cover Emergency Services:

- Without requiring prior authorization;
- Regardless of whether the provider is in-network; and
- Regardless of any other term or condition of the plan other than the exclusion or coordination of benefits, or a permitted affiliation or waiting period.

No Surprise Billing – Requirements

(c) Non-Emergency Services Provided by OON Providers at Certain Participating Health Care Facilities. The NSA cost sharing and balance billing protections apply when a group health plan covers items and services provided by an OON provider (health care professional) at an in-network health care facility, and the OON provider has not satisfied the notice and consent requirements with respect to such services.

- The participant can give up cost sharing and balance billing protections if the provider obtains the participant's informed written consent to waive such protections, in accordance with the notice and consent requirements of the No Surprises Act.
- However, the notice and consent requirements do not apply, and cost sharing and balance billing protections cannot be waived, with respect to: (1) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner; (2) items and services provided by assistant surgeons, hospitalists, and intensivists; (3) diagnostic services, including radiology and laboratory services, subject to certain exceptions; (4) items and services provided by a OON provider if there was no participating provider who could have furnished such item or service at the participating Health Facility; and (5) items or services furnished as a result of unforeseen, urgent medical needs that arose at the time the item or service was furnished, regardless of whether the OON provider satisfied the notice and consent requirements.

No Surprise Billing – Calculation of Participant Cost Sharing for Services Subject to Protection

- The Participant's cost-sharing amount for (1) OON Emergency Services and (2) certain non-emergency services furnished by OON providers at in-network facilities is determined based on the "Recognized Amount," which is:
  - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
  - If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law.
  - If neither of the above apply, the lesser of either the billed charge or the "Qualifying Payment Amount."
- The cost-sharing amount for OON air ambulance services is calculated using the lesser of either the billed charge or the plan's "Qualifying Payment Amount."

No Surprise Billing – Disclosure Requirement Regarding Balance Billing Protections

A plan must make publicly available, post on its public website, and include in each EOB for an item or service subject to the balance billing protections of the NSA, certain disclosures regarding the prohibition on surprise billing and the government entities to contact in the event of a violation.

The Departments have issued a model notice, the use of which (in accordance with the accompanying instructions) constitutes good faith compliance with this requirement.

Effective for plan years beginning on or after January 1, 2022. The Departments may address this requirement in more detail in future guidance.

Code § 9820(c), ERISA § 720(c), and PHSA § 2799A-5(c), as added by section 112 of the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act 2021.

No Surprise Billing – Payment to Providers

For the 3 categories of claims subject to NSB protections:

Initial Payment or Denial – The plan must send an initial payment or notice of denial of payment to the OON provider within 30 calendar days after the bill is transmitted by the provider. The denial notice must satisfy certain content requirements.

Open Negotiation Period – If the plan and provider cannot agree on a payment amount (referred to as the "out-of-network rate"), the parties must undertake an open negotiation period of up to 30 business days before they can initiate the IDR process. Strict deadlines apply and standard forms must be used.

Independent Dispute Resolution (IDR) – If the plan and provider cannot agree on the "out-of-network rate" by the end of open negotiation, either party may initiate the Independent Dispute Resolution (IDR) process. The parties have only 4 business days after exhausting open negotiation to initiate IDR.

No Surprise Billing – Payment to Providers

Total Plan Payment – The plan must pay a total plan payment directly to the OON provider that is equal to the amount by which the out-of-network rate for the services exceeds the participant's cost-sharing amount for such services, less any initial payment made by the plan. If applicable, such payment must be made within 30 days after the date on which a payment amount is determined through open negotiations or the IDR process.

Out-of-Network Rate – The "out-of-network rate" is:

- The amount determined by an applicable All-Payer Model Agreement.
- If there is no applicable All-Payer Model Agreement, an amount determined under a specified state law applicable to the plan.
- If neither of the above apply, an amount mutually agreed on by the parties or, as applicable, the amount determined by a certified IDR entity under the independent dispute resolution process.

No Surprise Billing – Independent Dispute Resolution (IDR)

- IDR is a paper review process (i.e., no hearings) in which each party submits an offer of an "out-of-network rate," along with other required information, and an independent reviewer (called the "certified IDR entity") selects one of the offers.
- For each step of the process, strict deadlines apply, standard forms/notices must be used, and notices to the government must be submitted online via the Federal IDR portal. Limited extensions are available (except for the timing of payments between the parties) on a discretionary, case-by-case basis.
- There are 2 sets of fees:
  - **Administrative Fee**: Each party must pay a non-refundable administrative fee to the government for participating in IDR (for 2022: $50 per party).
  - **Certified IDR Entity Fee**: The losing party must pay the entire Certified IDR Entity Fee (for 2022: $200-$500 for single determinations and $268-$670 for batched determinations). Technically, both parties must each pay the entire fee upfront, and the winning party will get a refund.

No Surprise Billing – IDR

- The certified IDR entity:
  - Is jointly chosen by the parties from a list available on the Federal IDR portal (or randomly by the government if the parties fail to make a selection by the deadline).
  - Must satisfy certain requirements, including not having a conflict of interest.
  - Must review the offers to determine whether IDR applies.
- The certified IDR entity must select one of the offers and notify the parties and the government of its selection within 30 business days. The certified IDR entity's determination is generally binding on the parties and not subject to judicial review. In making its decision, there is a list of factors that the IDR entity is required to consider, and a list of factors that it is not permitted to consider.
- Any required payment between the parties must be made within 30 calendar days after the certified IDR entity's determination.
- If a state has a law that regulates the way in which certain out-of-network claims are treated, insured group health plans may be subject to such state laws. State law will not apply to self-insured plans.

Code § 9816(c), ERISA § 716(c), and PHSA § 2799A-1(c), as added by section 103 of the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act 2021; Interim Final Rule: Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55980 (October 7, 2021).

No Surprise Billing – IDR

Texas Medical Ass'n, et al. v. United States Department of Health and Human Services, et al., Case No. 6:21-cv-425-JDK (E.D. Tex., Feb. 23, 2022).

The plaintiff challenged the Interim Final Rules that govern the federal independent dispute resolution (IDR) process issued pursuant to the NSA ("Requirements Related to Surprise Billing; Part II," 86 Fed. Reg. 55,980 (Oct. 7, 2021)).

Holding: Certain provisions of the Interim Final Rules must be set aside under the Administrative Procedure Act (APA) because:

- They conflict with the NSA. Specifically, the NSA does not assign greater importance to any one of the factors that the arbitrator must consider in reaching its decision, but the Interim Final Rules require the arbitrator to select the offer most closely aligned with the Qualifying Payment Amount ("QPA") unless a party demonstrated credible evidence that the result should be materially different. The court opined that this rule unduly favors payors and places an undue burden of proof on providers.
- The defendants (the government) improperly bypassed notice and comment required by the APA.

Remedy: The court vacated the disputed provisions of the Interim Final Rules.

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ESBA Response

On February 28, 2022, EBSA issued a memorandum in response to the district court's decision indicating that (1) it is considering how to proceed and (2) it will be updating existing guidance to conform to the court's decision.

NOTE: This case does not set aside the entire federal IDR process set forth in the Interim Final Rules. It just invalidates the provisions directing the arbitrator to give deference to the QPA.

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Impact on IDR: As a result of this case, the certified IDR entity will weigh all factors listed in the statute in choosing between each party's offer. These factors are:

- The QPA
- Creditable information submitted by the parties in response to the certified IDR entity's request; and
- Creditable information provided by the parties relating to the following:
  - The level of training, experience, and quality and outcomes measurements of the provider that furnished the item or service;
  - The market share held by the provider or the plan in the geographic region in which the item or service was provided;
  - The acuity of the individual receiving the item or service or the complexity of furnishing the item or service to the individual;

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- The teaching status, case mix, and scope of services of the facility that furnished the item or service, if applicable; and
- Demonstrations of good faith efforts (or lack thereof) made by the provider or the plan to enter into network agreements with each other, and, if applicable, contracted rates between the provider and the plan during the previous four plan years.

The certified IDR entity is still prohibited from considering the following factors in making its decision (the Texas case did not affect this rule):

- Usual and customary charges;
- The provider's billed charge; and
- The payment or reimbursement rate payable by a public payor, including under the Medicare, Medicaid, CHIP, TRICARE, or VA programs.

ID Cards

ID cards (whether physical or electronic) must include:

- Any applicable deductibles (for both in and out-of-network),
- Any applicable out-of-pocket maximum limitations, and
- A telephone number and website address for individuals to seek consumer assistance.

Code § 9816(e), ERISA § 716(e), and PHS Act § 2799A–1(e), as added by section 107 of the No Surprises Act, Title 1 of Division BB of the Consolidated Appropriations Act 2021.

Effective Date: Effective for plan years beginning on or after January 1, 2022.

The Departments intend to engage in future rulemaking addressing implementation of the ID card requirements, including how plans and issuers offering complex plan and coverage designs should represent information on an ID card. Pending future rulemaking, plans and issuers are expected to implement the ID card requirements using a good faith, reasonable interpretation of the law.

FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 49 (August 20, 2021), Q&A 4.

Prohibition On Gag Clauses

Group health plans and health insurance issuers cannot enter into an agreement with a provider, network or association of providers, third party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from:

(1) Providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants/beneficiaries, or individuals eligible to become participants/beneficiaries of the plan or coverage;

(2) Electronically accessing de-identified claims and encounter data for each participant/beneficiary; and

(3) Sharing such information, consistent with applicable privacy regulations.

In addition, plans must annually submit to the Departments an attestation of compliance with these requirements.

Effective Date:

Effective December 27, 2020 (the date of enactment of the CAA 2021).

- Until any further guidance is issued, plans and issuers must implement these requirements using a good faith, reasonable interpretation of the statute.
- The Departments intend to issue implementation guidance explaining how plans should submit their attestations of compliance and anticipate beginning to collect attestations starting in 2022.

Code § 9824, ERISA § 724, and PHSA § 2799A-9, as added by Section 201 of Title II ("Transparency") of Division BB of the Consolidated Appropriations Act 2021; FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 49 (August 20, 2021), Q&A-7.

Accuracy Of Provider Directories

Group health plans must:

- Establish a database on the public website of the plan or issuer that contains:
  - A list of each health care provider and facility with which such plan or such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan; and
  - Provider directory information (name, address, specialty, telephone number, and digital contact information) for each such provider/facility.
- Establish a process to update and verify the accuracy of provider directory information;
- Establish a protocol for responding to participant requests by telephone or electronic, web-based, or internet-based means about whether a provider has a contractual relationship to furnish items and services under the plan.
  - If a request is made by telephone, the plan must (1) respond to the request as soon as practicable but no more than 1 business day after such call is received, (2) provide such response in a written electronic or print (as requested by the individual) communication, and (3) retain the written communication in the individual's file for at least 2 years following such response.

Accuracy Of Provider Directories

- Include a notification in any print directory that contains provider directory information informing participants that the information contained in the directory was accurate as of the date of publication and that they should consult the electronic directory for the most current provider directory information with respect to the plan.
- If a participant receives services from a nonparticipating provider after obtaining inaccurate information from a plan or issuer under its required provider directory or response protocol that the provider or facility was a participating provider -
  - The plan or issuer cannot impose cost-sharing greater than the cost-sharing that would be applied if the items and services were furnished by a participating provider or facility and must apply the deductible or out-of-pocket maximum that would apply if such item or service had been provided by a network provider.

These requirements do not preempt state laws relating to health care provider directories.

Effective Date: Effective for plans years beginning on or after January 1, 2022.

Code § 9820(a) and (b), ERISA § 720(a) and (b), and PHSA § 2799A-5(a) and (b), as added by section 116 of the No Surprises Act, Title 1 of Division BB of the Consolidated Appropriations Act 2021.

Continuity Of Care – Definitions

"Continuing Care Patient" is an individual who, with respect to a provider or facility –

1. is undergoing a course of treatment for a "serious and complex condition" from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo nonelective surgery (including receipt of postoperative care) from the provider or facility;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; OR
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from the provider or facility.

A "serious and complex condition" means either:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; OR
- In the case of a chronic illness or condition, a condition that (i) is life-threatening, degenerative, potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

"Terminated" means with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Continuity Of Care – Requirements

If an individual under a group health plan qualifies as a continuing care patient with respect to a health care provider or facility that has a contractual relationship with the plan, and

i. The contractual relationship is terminated,

ii. Benefits provided under the plan with respect to such provider or facility are terminated due to a change in the terms of the contractual agreement, or

iii. A contract between the plan and an insurer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility,

Continuity Of Care – Requirements

Then, the Plan must:

- Timely notify each participant in the plan who is a continuing care patient with respect to the provider of the right to elect continued transitional care from the provider;
- Provide each such patient with an opportunity to notify the plan of the individual's need for continued transitional care; and
- Permit the patient to elect continued transitional care with the provider (only with respect to the course of treatment relating to the condition(s) that make the patient a continuing care patient), under the same terms and conditions as would have applied had the termination not occurred.
  - Such continued transitional care is for the period beginning on the date notice is provided to the patient and ending on the earlier of: (i) 90 days from the date notice was provided; or (ii) the date on which the patient is no longer a continuing care patient with respect to the provider.

Effective Date: Effective for plans years beginning on or after January 1, 2022.

Code § 9818, ERISA § 718, and PHSA § 2799A-3 and 2799B-8, as added by section 113 of the No Surprises Act, Title 1 of Division BB of the Consolidated Appropriations Act 2021.

Continuity Of Care – Considerations

- For each provider network, who will be responsible for notifying the plan administrator that there has been a termination of a provider agreement? Alternatively, is the plan administrator responsible for obtaining that information, by for example, looking it up on the network provider's website?
- When there is a termination of a provider from a network, who will be responsible for sending notices and election forms to Continuing Care Patients? Who will be responsible for administering Continuity of Care?
- Will notices be sent only to Continuing Care Patients or to all patients of the Terminated provider? (Is it realistic to determine which patients are or may be Continuing Care Patients prior to sending notices).

Good Faith Estimates For The Provider

NOTE: This is a requirement for providers, not plans.

Upon an individual's scheduling of items or services (or upon request), providers must (1) inquire if the individual has health coverage and (2) provide a good faith estimate of the expected charges for furnishing the scheduled item or service (and any items or services reasonably expected to be provided in conjunction with those items and services, including those furnished by another provider), along with the expected billing and diagnostic codes.

The provider must provide this good faith estimate within specified timeframes to:

- The individual's plan or coverage, if the individual is seeking to have a claim for the item or service submitted to the plan or coverage. Receipt of this good faith estimate will trigger the plan's obligation to provide an Advanced EOB (discussed on a separate slide).
- The individual, if the individual does not have health coverage or wants to self pay (i.e., does not want to file a claim).

Effective Date: These provisions apply with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022. However, enforcement with respect to providing good faith estimates to plans and issuers has been deferred pending issuance of regulations.

PHSA § 2799B-6, as added by section 112 of the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act 2021.

Advanced EOBs

Plans must send patients "Advanced EOBs" (by mail or electronically based on patient preference) upon receiving either (1) a notice of scheduled services from a provider (i.e., the good faith estimate) or (2) a request by a patient seeking more information prior to scheduling.

The Advanced EOB must be provided within the following timeframes:

- *If the notice is from the provider*:
  - Within 3 business days of receiving the notice, if the services are scheduled at least 10 business days after the notice; or
  - Within 1 business day of receiving the notice, if the services are scheduled within 10 days of the notice.

- *If the request is from a patient*: Within 3 business days of receiving the request.

Advanced EOBs

Content Requirements:

Advanced EOBs must include (1) whether the provider or facility is in-network for that item or service, (2) the contracted rate (if applicable), (3) if the provider is OON, a description of how to obtain information on in-network providers, (4) good faith estimates of the provider's charge, the plan's responsibility, the participant cost sharing, and the participant's accumulated amounts (e.g., deductible, OOP max), and (5) disclaimers/other information.

Effective Date: Effective for plan years beginning on or after January 1, 2022. However, enforcement is deferred pending issuance of regulations expected later this year.

Code § 9816(f), ERISA § 716(f), and PHSA § 2799A-1(f), as added by section 111 of the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act 2021.

Price Comparison Tool

Plans must offer participants price comparison guidance by telephone and make available on the plan's website a price comparison tool that allows participants to compare the amount of cost-sharing for a specific item or service with respect to the plan year, geographic region, and participating providers.

Effective Date: Effective for plans years beginning on or after January 1, 2022. However, enforcement is deferred until plan years beginning on or after January 1, 2023 (to align with the compliance date of the Transparency Final Rule's price comparison requirement).

> **Note**: *Because the price comparison tool requirement under the CAA is largely duplicative of the internet-based self-service tool component of the Transparency Final Rule, the Departments are deferring the effective date of the CAA requirement and looking into whether compliance with the Transparency Final Rule requirement satisfies the analogous CAA price comparison tool requirement.*

Code § 9819, ERISA § 719, and PHSA § 2799A-4, as added by section 114 of the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act 2021.

Air Ambulance Reporting

Plans and issuers must submit reports to HHS on air ambulance claims for calendar years 2022 and 2023. The reports must contain:

1. Claims data for air ambulance services (such as the type of aircraft, whether the services were furnished in a rural or urban area); and
2. Other information regarding providers of air ambulance services.

Proposed regulations published on September 16, 2021, set forth the data requirements for these reports. To facilitate reporting, the Departments intend to publish additional technical details, including a proposed data template and instructions.

Plans are not required to report information if they did not receive claims or make or expect to make payments for air ambulance services during the reporting period.

Due Date:

The first report (pertaining to data on air ambulance services furnished and payments made for calendar year 2022) must be submitted on March 31, 2023.

The second report (for calendar year 2023) must be submitted by March 31, 2024.

Code § 9823, ERISA § 723, and PHSA § 2799A-8, as added by section 106(b) of the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act 2021. Proposed 45 CFR § 149.230.

REPORTING ON PHARMACY BENEFITS AND DRUG COSTS

Requirement:

- Group health plans/insurers must submit annual reports on prescription drug and health care spending to the DOL/HHS/IRS. The reports must contain certain specified information, such as the top 50 brand prescription drugs by frequency, the total number of paid claims for each drug, and the total medical and prescription drug spend broken down into various categories.

HHS has released data submission instructions for the 2020 reference year, which include instructions on how the data is to be submitted and detailed explanations and examples.

The DOL will use this information to compile a report (available on its website) on prescription drug reimbursements, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases.

REPORTING ON PHARMACY BENEFITS AND DRUG COSTS

Due Dates:

The first reporting deadline was originally set to be December 27, 2021 (for calendar year 2020 information), with subsequent deadlines on June 1 of each succeeding year. The first two reporting deadlines, however, have been deferred pending the issuance of further guidance. The agencies will not initiate enforcement actions against plans/insurers that submit the required data for the 2020 and 2021 calendar years by December 27, 2022. Plans/insurers are urged to start working to ensure that they are be able to report by December 27, 2022, and are encouraged to submit by either the December 27, 2021 or June 1, 2022 deadlines if they are able.

Code § 9825, ERISA § 725, and PHSA § 2799A-10, as added by section 204 of Title II (Transparency) of Division BB of the Consolidated Appropriations Act 2021; FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (August 20, 2021), Q&A-12; Interim Final Rule: Prescription Drug and Health Care Spending, 86 Fed. Reg. 66662 (Nov. 23, 2021).

Transparency Final Rule

Additional price transparency rules that are not part of the CAA 2021 were issued on November 12, 2020 (referred to as the "the TiC Final Rules").

The TiC Final Rules apply to non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets, but not to excepted benefits, account-based plans (e.g., HRAs), and short-term, limited-duration insurance.

There is protection for good faith compliance.

The TiC Final Rules have 2 components:

- **Machine-Readable Files**
- **Price Comparison Information via Internet-Based Self-Service Tool**

Transparency Final Rule

Machine-Readable Files

Plans and issuers must post 3 machine-readable files online (i.e., readily accessible at no cost on its public website) that include:

- In-network provider rates for covered items and services,
- Out-of-network allowed amounts and billed charges for covered items and services, and
- Negotiated rates and historical net prices for covered prescription drugs.

All 3 files must contain certain required information, such as billing codes, and must be updated monthly.

"Machine-readable file" is defined as "a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost." Examples include JavaScript Object Notation (JSON), Extensible Markup Language (XML), or Comma Separate Value(s) (CSV). PDFs, however, are not acceptable.

Effective Date: Plan years (in the individual market, policy years) beginning on or after January 1, 2022. However, enforcement of the requirement with respect to in-network rates and out-of-network allowed amounts and billed charges has been deferred until July 1, 2022, and enforcement of the requirement with respect to prescription drugs has been deferred indefinitely, pending further rulemaking.

Transparency Final Rule

Price Comparison Information via Internet-Based Self-Service Tool

Plans and issuers must make price comparison information available at no cost to participants, beneficiaries, and enrollees through an internet-based, self-service tool and in paper form, upon request. The information must include seven (7) content elements, including estimated cost-sharing liability for covered items or service furnished by a particular provider and a disclosure notice (a model notice is available).

Effective Date: This information must be available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to 500 items and services listed in Table 1 in the preamble to the TiC Final Rules. For plan years (or policy years) beginning on or after January 1, 2024, it must include all covered items and services.

PHSA § 2715A; Final Rule: Transparency in Coverage, 85 Fed. Reg. 72158 (Nov. 12, 2020); FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49, Q&As-1, -2 and -3 (Aug. 20, 2021).