ALSTON & BIRD

WWW.ALSTON.COM

Employee Benefits & Executive Compensation ADVISORY ■

FEBRUARY 4, 2021

Group Health Plan Provisions of the Consolidated Appropriations Act: A Deeper Dive

***By** John Hickman, Ashley Gillihan, Carolyn Smith, Kenneth Johnson, Amy Heppner,* **and** *Earl Porter*

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA) was signed into law. In addition to funding the government and further COVID-19 relief, the CAA included significant provisions impacting health benefit coverage. Four of these provisions are relevant for group health plans: (1) expanded relief for health and dependent care flexible spending arrangements; (2) new expanded compliance requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA); (3) new reporting requirements for commission and similar compensation; and (4) new requirements to limit surprise billing.

Health and Dependent Care Assistance Flexible Spending Arrangements

In 2020, the Department of the Treasury and Internal Revenue Service issued Notice 2020-29 that provided an extended grace period for unused funds in health flexible spending arrangements (FSAs) and dependent care FSAs (DCAPs), as well as additional opportunities to change elections for health coverage and FSA benefits. The IRS also released Notice 2020-33, which increased the amount of the carryover permitted for health FSAs to $550 due to inflation indexing.

A portion of the CAA, the Taxpayer Certainty and Disaster Tax Relief Act, expands on the prior IRS relief. As was the case with the IRS relief, employers may choose whether to adopt any of the options provided in the Relief Act. If an employer adopts any of these options, a plan amendment (potentially retroactive) needs to be made by the end of the calendar year following the plan year the change relates to.

Extension of carryover amounts for health FSAs and DCAPs

Health FSA and DCAP balances that are unused in 2020 may be carried over into 2021, and unused balances in 2021 may be carried over into 2022. There is no limit on the amount of permitted carryover. The prior IRS guidance allowed a more limited carryover only for health FSAs (not DCAPs). There are special issues to consider for employers that have high deductible health plans (HDHPs) and want to provide a health FSA carryover. Employers that offer an HDHP should consider steps to protect ongoing health savings account (HSA) eligibility for employees (e.g., by restricting carryover funds in a health FSA for those who elect an HDHP to limited purpose vision/dental coverage).

DCAP benefits are subject to Form W-2 and participant reporting requirements that must be considered in connection with a carryover or grace period. More specifically, employers are required to report DCAP benefits on employee Forms W-2 each year. The IRS has previously provided guidance allowing employers to report DCAP benefits based on the amount of salary reductions and has confirmed that this treatment still applies when a plan has a grace period. Presumably, the same rules apply to an extended 12-month grace period and a DCAP carryover.

Similarly, potential issues can arise if a carryover or grace period causes the amount of DCAP benefits received in a year to exceed the $5,000 maximum exclusion allowed for a DCAP. DCAP participants are required to report their excludable DCAP benefits on Form 2441 filed in conjunction with their annual Form 1040. IRS Form 2441 notes that DCAP amounts are to be reported in the year they are used and that any amounts used in a year exceeding the annual $5,000 limit should be reported as taxable compensation on Forms 2441 and 1040. Presumably the same rules would apply to an extended 12-month grace period and a DCAP carryover.

Extension of grace periods for health FSAs and DCAPs

Normally, health FSAs and DCAPs may provide a grace period of up to 2-1/2 months immediately following the end of each plan year (e.g., up to March 15 for a calendar-year plan year). Any used amounts remaining at the end of the plan year may be used to pay expenses incurred for the same benefits during the grace period. The Relief Act permits a grace period for unused benefits in health FSAs and DCAPs to be extended to 12 months for plan years ending in 2020 or 2021. [Note that the Relief Act references an "extension" of the grace period; query whether such language could also apply to the extension of a grace period for the first time. We think it should, but formal confirmation would be welcome.]

The Relief Act does not address whether the extended grace period can be limited by plan design in amount or in duration. Under the pre-COVID-19 grace period guidance, plan sponsors could limit carryovers to specified amounts (e.g., no more than $2,000). Also, it would seem that a plan sponsor should be able to choose to restrict the extended grace period to less than 12 months. Presumably, agency guidance will confirm that plan sponsors have similar leeway with the extended grace period under the Relief Act.

As with the carryover, ongoing grace period coverage in a general-purpose health FSA would make an individual ineligible for an HSA for the entire period of coverage. Employers that offer an HDHP and are considering the grace period extension for a health FSA should also consider steps to protect ongoing HSA eligibility (e.g., by limiting the grace period duration or by restricting the use of unused funds for all participants to limited purpose vision/dental coverage).

> ***Practice Pointer****:* Which is better, a 12-month grace period or a carryover? In many respects, for plan years ending in 2020 and 2021, both the extended grace period and the carryover accomplish the same thing – a carryover of unused funds. In some cases, the carryover may be advantageous because it would allow funds to move forward from 2020 to 2021 and 2021 to 2022. The grace period may only allow associated funds to move forward a single year before forfeiture, and if required, this feature may also be problematic for some third-party administrators (TPAs). Otherwise, it may come down to a matter of which approach employees are most familiar with and which arrangement might be continued after 2021. In addition, it is worth noting that employers that also sponsor an HDHP may be more comfortable with the carryover since the guidance relating to restricting existing balances for individual participants to a limited purpose vision/dental FSA based on a prospective HDHP election is clearer with the carryover.

Temporary expansion of eligible dependent to age 13 for 2020; also for 2021 for unused DCAP grace period or carryover funds

Normally, DCAP benefits may be provided for eligible dependents through age 12 (i.e., dependents who have not turned age 13). The Relief Act permits employers to reimburse DCAP expenses for eligible dependents through age 13 (i.e., dependents who have not attained age 14) for the 2020 plan year. In order for this relief to apply, the plan's regular annual enrollment period must have ended on or before January 31, 2020. The same relief also applies for the next plan year, but only for unused grace period amounts from the 2020 plan year or other amounts carried over into the 2021 plan year. Plan sponsors seeking to avail themselves of this change should ensure that their administrators can differentiate between carryover and non-carryover funds in processing claims for age 13 dependents.

Prospective election changes during 2021 for health FSAs and DCAPs

Prospective changes in health FSA and DCAP elections may be made for plan years ending in 2021 without a corresponding change-in-status event. This is a one-year extension of the relief provided in IRS Notice 2020-29 except that the extended relief applies only to FSAs. Again, while the Relief Act is somewhat ambiguous, the relief likely applies to employees making new FSA elections since these employees had previously made an election not to participate. Employers considering such a provision may want to impose reasonable restrictions on the number of such changes and to possibly restrict prospective FSA reductions to be no lower than the amount of benefits already paid.

Post-termination spend down for health FSA funds

Plans may permit health FSA participants who terminate participation in the plan during the 2020 or 2021 plan year to spend down their unused balances for expenses incurred through the end of the plan year in which the termination occurred, including any grace period extension. This approach is similar to what is and has always been permitted for DCAPs. Under such an approach, FSA reimbursements are limited to the amount of unused FSA contributions.

The Relief Act does not address whether the health FSA spend down can be limited by plan design in amount or in duration. It would seem that a plan sponsor should be able to choose to restrict the period for a spend-down provision (e.g., until 90 days following termination). Also, steps should be taken to coordinate the spend down with any COBRA coverage required for the health FSA. Presumably, the spend down would be offered as a mutually exclusive alternative to COBRA coverage. As with the grace period extension and carryover provisions, ongoing coverage in a general-purpose FSA will adversely impact HSA eligibility for the entire period of coverage.

Plan sponsor considerations

The FSA relief under the Relief Act is temporary (applicable only for plan years ending in 2020 or 2021) and discretionary. Plan sponsors should evaluate their individual circumstances and decide whether changes are appropriate for their plans. In some cases, the COVID-19 pandemic may have caused a large amount of potential forfeitures (e.g., because daycare centers and/or health care providers were closed). The FSA relief may make sense in such cases. In other situations, forfeitures may be small and there may not be a need for the expanded FSA carryover or grace period relief. Fortunately, employers may have a little time to consider which approach may be best for them since Relief Act FSA amendments can be adopted retroactively.

Documenting MHPAEA Compliance

The CAA imposed new MHPAEA compliance requirements on group health plans and insurers. The CAA specifically mandates that group health plans and insurers perform and document an MHPAEA comparative analysis of a plan's or policy's nonquantitative treatment limitations (NQTLs) and provide such documentation to the auditing agency upon request.

Background

The MHPAEA is designed to require benefit parity between medical and surgical (Med/Surg) benefits and mental health and substance use disorder (MH/SUD) benefits. Plans that provide Med/Surg benefits and MH/SUD benefits must provide parity as defined under the MHPAEA for (1) financial requirements (e.g., deductibles, copayments, coinsurance, and out-of-pocket maximums); (2) quantitative treatment limitations (e.g., number of visits or treatments or days of coverage); and (3) NQTLs, discussed below. The new requirements relate to NQTLs.

Since the MHPAEA's provisions fall under three distinct statutes, the Internal Revenue Code, Public Health Service Act (PHSA), and ERISA, enforcement falls under three federal agencies: the Internal Revenue Service, Department of Health and Human Services (HHS), and Department of Labor (DOL) (the tri-agencies). Also, state departments of insurance have primary enforcement authority over fully insured plans. The MHPAEA applies not only to ERISA-covered plans but

also to church plans (through the Code) and to state and local governmental plans (through the PHSA). Self-funded state and local governmental plans may opt out of MHPAEA requirements.

MHPAEA compliance has been a primary focus in DOL audits of group health plans over the last several years. In a 2020 MHPAEA Enforcement Fact Sheet, the DOL acknowledged that "multi-year investigations are not uncommon with respect to complex MHPAEA issues, especially for investigations that involve large service providers (such as issuers, third-party administrators, and managed behavioral health organizations)."

NQTLs

As a general rule, NQTLs cannot apply any more stringently to MH/SUD benefits than they apply to Med/Surg benefits. The following is a nonexclusive list of NQTLs:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative.
- Prior authorization or ongoing authorization requirements.
- Concurrent review standards.
- Formulary design for prescription drugs.
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design.
- Standards for provider admission to participate in a network, including reimbursement rates.
- Plan or issuer methods for determining usual, customary, and reasonable charges.
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols).
- Exclusions of specific treatments for certain conditions.
- Restrictions on applicable provider billing codes.
- Standards for providing access to out-of-network providers.
- Exclusions based on failure to complete a course of treatment.
- 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 or coverage.

The DOL has issued several useful tools for NQTLs, including a Self-Compliance Tool and a listing of MHPAEA NQTL Warning Signs.

Under the MHPAEA, benefits are broken down into six different classifications: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs. MHPAEA regulations prohibit a group health plan from imposing NQTLs on MH/SUD in a classification unless, under the terms of the plan *as written and in operation*, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the limitation on Med/Surg benefits in the same classification.

The parity analysis requires not only identifying the NQTLs as written and in operation but also examining the factors considered in the design of the NQTLs. Examples of factors include:

- Excessive utilization.
- Recent medical cost escalation.
- Provider discretion in determining diagnosis.

- Lack of clinical efficiency of treatment or service.
- High variability in cost per episode of care.
- High levels of variation in length of stay.
- Lack of adherence to quality standards.
- Claim types with high percentage of fraud.
- Current and projected demand for service.

Then the sources for the factors must be examined. Examples of sources include:

- Internal claims analysis.
- Medical expert reviews.
- State and federal requirements.
- National accreditation standards.
- Internal market and competitive analysis.
- Medicare physician fee schedules.
- Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

Group health plans must demonstrate that any factor used, evidentiary standard or source relied upon, and process employed in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD benefits than Med/Surg benefits.

Needless to say, this is a huge and difficult undertaking. In our experience, many self-funded group health plans have not undertaken the exercise of documenting an NQTL analysis and compliance. This is not a service normally performed by a TPA or pursuant to an administrative services only (ASO) agreement with an insurer. The Self-Service Tool is a useful start and framework for such an analysis.

New requirements

There has never been a specific requirement to have a documented NQTL analysis, although MHPAEA compliance had been required for well over a decade, and the DOL frequently requests such an analysis when it performs a group health plan audit. The CAA now mandates that group health plans and insurers *shall perform and document comparative analyses of the design and application of NQTLs*. The CAA requirements are specific for the NQTL analysis, which must identify the NQTLs, identify the factors used to determine the NQTLs, identify the evidentiary standards and sources used to develop the factors, perform a comparative analysis, and make specific findings and conclusions.

Beginning February 10, 2021 (45 days after the date of enactment), a comparative analysis of the NQTLs must be provided upon request to state regulators (e.g., a state department of insurance for an insured plan) or to any one of the tri-agencies. Each of the tri-agencies is required to request at least 20 NQTL analyses per year.

The request from each tri-agency may be based on individual complaints, identification of potential violations of the MHPAEA, or "any other instances in which the [tri-agency] determines appropriate." The tri-agency will then review the NQTL analysis, and if it finds it noncompliant, the plan/insurer has 45 days to provide an analysis showing NQTL compliance. If a plan/insurer fails to demonstrate compliance in that 45-day period, then within seven days of the determination of noncompliance, the tri-agency will notify all individuals enrolled in the plan or policy of the noncompliance.

There remains much uncertainty on when an NQTL might violate the MHPAEA, although recent years have seen increased guidance from the tri-agencies. The CAA has provisions similar to the 21st Century Cures Act (2016), which required the tri-agencies to take certain steps to promote understanding and compliance with the MHPAEA. The CAA requires the tri-agencies to develop a "compliance program guidance document" that will provide de-identified examples of NQTL compliance and noncompliance and other recommendations to advance NQTL compliance. That document must also provide information on how plans and insurers may disclose information in compliance with the MHPAEA. The deadline for issuing this guidance is 18 months after enactment (late June 2022). The guidance should also provide further information on the process and timelines for participants and beneficiaries to file complaints for alleged MHPAEA violations. The compliance program guidance document must be updated every two years.

Summary and action items

Now is the time to perform an MHPAEA NQTL comparative analysis if one has not already been performed. Even if an NQTL comparative analysis has been performed, it needs to be reviewed under the new requirements. The tri-agencies could be asking for such an analysis as early as February 10, 2021. And for the last several years, the DOL has requested the analysis as part of its group health plan audit protocol.

The tri-agencies' goal, however, appears to be one of better overall compliance. That said, the DOL will take action if it discovers noncompliance. Sanctions for violations of the MHPAEA under ERISA are limited to what is known as "equitable relief," which can include requiring a plan to reprocess claims if they were improperly denied or not fully reimbursed because of a noncompliant NQTL. Depending on the volume of claims involved, reprocessing can be a burdensome and expensive proposition. There is, however, no civil monetary penalty for MHPAEA violations under ERISA. The DOL also has no direct jurisdiction over insurance issuers, although when it discovers a violation, it often threatens action against employer plan sponsors and will frequently work with insurers and state departments of insurance to bring policies into compliance. Under the Code, there can be an excise tax for MHPAEA violations of $100 per day for each individual a failure relates to.

There has also been a significant uptick in MHPAEA litigation by private parties under ERISA. These cases often involve NQTLs, and having a NQTL analysis establishing compliance could go a long way in preventing those claims or defending any that are brought.

Broker and Consultant Disclosures for Health Care Services

The CAA contains new service provider disclosure requirements for "brokerage services" and "consulting" services and requires group health plan fiduciaries to take action if they do not receive those disclosures. The effective date of this provision is December 27, 2021 (one year from the date of enactment). We expect future guidance from the DOL to fill in some of the gaps and ambiguities in the statutory provisions.

Background

ERISA Section 406 provides that furnishing services between a plan and a "party in interest" is a prohibited transaction. A party in interest includes any person providing services to a plan. Looking at ERISA Section 406 alone, this would make almost all arrangements between plans and plan service providers prohibited transactions. There is an exception, however, in ERISA Section 408(b)(2) for contracts or arrangements for services with a party in interest if the arrangement is reasonable, the services provided are necessary for the establishment or operation of the plan, and no more than reasonable compensation is paid.

Current DOL regulations require *retirement plan* service providers to disclose both the direct and indirect compensation they receive. The DOL reasoned that it is impossible for a "responsible fiduciary" to know whether compensation or an arrangement is reasonable unless that plan fiduciary knows what compensation the service provider receives for each service rendered. Therefore, under those regulations, an arrangement with a service provider where such

disclosures are not made is not "reasonable" and could generally result in a prohibited transaction (with certain exceptions when the plan fiduciary takes action for the service provider's failure to disclose). Finding that there were significant differences between service provider arrangements with welfare plans and with retirement plans, the DOL did not issue guidance for welfare plans at that time.

The CAA now institutes disclosure requirements for certain service providers to "group health plans" by amending Section 408(b)(2) of ERISA. These statutory requirements, in many ways, mirror the regulatory requirements applicable to retirement plans and are modeled on the regulatory provisions. Some of what is below, therefore, may be familiar for plan fiduciaries and plan sponsors who are acquainted with the required retirement plan disclosures. The CAA's rules will likely be new for many group health plan brokers and consultants, and planning should begin immediately on how these disclosures will be implemented.

Covered plans and covered service providers

The CAA's amendment to ERISA Section 408(b)(2) covers "group health plans," which are defined as employee welfare plans that provide "medical care." Significantly, the CAA does not exempt what are known as "excepted benefits" from this definition of a group health plan. So the CAA sweeps in not only traditional fully insured and self-funded group medical plans but also dental and vision plans, health FSAs, on-site clinics (except those that are limited to only rendering first aid to employees during working hours), many employee assistance programs, and health reimbursement arrangements (HRAs). Examples of plans that are not group health plans are group term life insurance, accidental death and dismemberment insurance, and long- and short-term disability insurance. Also, while HSAs are generally not group health plans, the HDHP that accompanies an HSA is a group health plan.

Disclosure is required only if the service provider receives $1,000 or more in certain types of compensation pursuant to the consulting or brokerage contract or arrangement. Compensation includes "direct compensation" from the covered plan itself or "indirect compensation," which is compensation from any source other than the covered plan, the plan sponsor (often the employer), the service provider, or an affiliate of the service provider. In other words, if the only compensation that the service provider receives derives directly from the employer, then disclosure is not required. This could arise, for example, with a consulting agreement for a self-funded group health plan where the employer is responsible for all fees associated with the agreement, no fees are paid with plan assets, and the service provider does not receive compensation from any other source for the plan. Plan assets can take the form of amounts paid from a formal trust or amounts paid with any participant contributions. So to avoid reporting, care must be taken to ensure that the service provider is not paid with any participant contributions (and that it does not receive indirect compensation). It appears that disclosure will be required for an insured arrangement, where a portion of the premiums that generate the insurance commissions are paid by plan participants, because those commissions will be deemed to be paid by the plan.

Disclosure is required regardless of whether the services are performed, or the compensation is received, by the service provider, its affiliate, or its subcontractor.

The CAA's amendment to ERISA Section 408(b)(2) covers two types of services as "covered service providers": brokerage services and consulting.

The definition of brokerage services includes a "selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services."

Consulting services are nearly identical but do not need to involve "brokerage" and include services "related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services."

We must wait for further clarification of these definitions, but the consulting category appears especially broad. It is unclear whether consulting just includes advising on the selection of service providers such as TPAs or pharmacy benefit managers or whether it also applies to the service providers themselves when they "consult" (e.g., a TPA consults on plan design or a pharmacy benefit manager consults on a plan's drug formulary). If it is the latter, then the disclosure requirement would potentially include not only insurance brokerage firms serving in a consulting capacity to self-funded plans but a host of other service providers, including:

- TPAs (both for self-funded group health plans and for health FSAs and HRAs).
- Stop-loss carriers, stop-loss panels, and stop-loss consortiums.
- Pharmacy benefit managers.
- Wellness vendors.
- Disease management vendors including data analytics.
- On-site clinic managers.
- Any entity providing "compliance services" (including attorneys and actuaries).
- Employee assistance program vendors.

What must be disclosed

The covered service provider must provide the following information (including the information of any affiliate or subcontractor):

- A description of the services provided.
- If applicable, a statement on whether the covered service provider will serve as an ERISA fiduciary.
- A description of all direct compensation the covered service provider reasonably expects to receive in connection with the services. There are several different ways compensation can be expressed, including a monetary amount or a formula.
- A description of all indirect compensation that the covered service provider reasonably expects to receive. This includes "compensation from a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan." We will need to wait for further guidance on what this would include, but it could relate to items such as a vendor providing brokers with gifts, trips, etc., for the amount of business they place with the vendor or even the vendor being a financial sponsor at a client-facing event held by the brokerage firm.
- A description of the arrangement under which the indirect compensation is paid.
- Identification of the services for which an indirect compensation will be received.
- Identification of the payer of the indirect compensation.
- A separate description of any compensation that is set on a transaction basis (such as commissions, finder's fees, or other similar incentive compensation based on business placed or retained) that will be paid among the covered service provider, affiliate, or subcontractor.
- A description of any compensation that the covered service provider will receive upon termination of a contract or arrangement.

Timing of disclosure

Disclosures must be made to the responsible plan fiduciary "reasonably in advance" of the date of entering into, extending, or renewing any contract or arrangement. Changes to the information disclosed must be provided as soon as practicable, but generally not later than 60 days from the date on which the covered service provider is informed of the change. If, however, a covered service provider acting in good faith and with reasonable diligence makes an error or omission with disclosure, the contract or arrangement may still be reasonable if the correct information is provided within 30 days after the error or omission is discovered.

The effective date of this provision is December 27, 2021. Contracts entered into before this date are not subject to these requirements, but any renewal or extension of a contract after the effective date is covered.

What if the disclosure is not made?

Upon discovery of a disclosure violation, a responsible fiduciary can avoid a prohibited transaction by taking the following actions. First, the responsible fiduciary should request, in writing, that the covered service provider make full disclosure. Second, if the covered service provider refuses to make full disclosure or does not respond within 90 days, then the DOL must be notified of the failure within 30 days following the earlier of the refusal to respond or the lapse of the 90-day period to respond. Section 408(b)(2) specifies the information that must be provided to the DOL. Finally, if the disclosure failure relates to past services, then the responsible fiduciary must make a determination on whether to retain the covered service provider based on ERISA's fiduciary prudence standards. If the failure relates to future services, then the responsible fiduciary must terminate the contract or arrangement as expeditiously as possible as consistent with those prudence standards.

Summary and action items

The clear intent of the CAA was to mirror the disclosure requirements of retirement service plan providers. Plan sponsors and fiduciaries may be familiar with this process from their experience with their retirement plans, but work still needs to be done. Actions for plans sponsors and fiduciaries include:

- Identify any person or entity that consults in any way with a group health plan and all brokers for any group health plan and determine if they are a covered service provider.
- Determine whether any covered service provider receives any direct compensation from any group health plan and the amount of that compensation.
- If known, determine whether the covered service provider receives any indirect compensation and the amount of that compensation.
- Prepare, once effective, to make a demand to any service provider that has not provided adequate disclosure.
- Establish and document that a responsible fiduciary actually reviews the disclosures and determines that the compensation arrangement for consulting or brokerage services is reasonable.

Group health plan brokers and consultants have a much heavier burden. They will need to analyze all instances when they receive either direct compensation or indirect compensation. The identification of any indirect compensation is especially crucial because the reason for this provision was a belief that group health plan brokers and consultants are receiving forms of "hidden" compensation. Also remember that these disclosures apply to all group health plans regardless of size as long as the compensation threshold is met. Finally, the disclosures must be designed and formatted to include all required information. This may require new software or revisions to existing software to automate these extensive disclosure requirements.

Provisions in the No Surprises Act

The No Surprises Act: (1) protects plan participants from surprise medical bills, i.e., balance bills from out-of-network (OON) providers in certain situations, including air ambulance services; (2) establishes an independent dispute resolution (IDR) process for resolution of any surprise medical bill between the provider and the health plan; and (3) imposes new disclosure and transparency requirements on health plans and providers. The provisions are effective for plan years beginning on or after January 1, 2022. The provisions applicable to group health plans are added to the Code, PHSA, and ERISA and apply to the same plans that are subject to the ACA health coverage mandates, including grandfathered plans. Retiree-only plans and "excepted benefits" (such as stand-alone vision and dental plans and specified disease polices) are not subject to these new requirements. Provisions relating to providers are added to the PHSA. We anticipate that many details will be fleshed out in tri-agency regulations. The legislation sets July 1, 2021 as a general date for issuance of regulations.

Plan Participants Protected from Surprise Medical Bills; Obligations of ACA Covered Group Health Plans (Including Grandfathered Plans)

The financial obligation of plan participants and beneficiaries is limited to in-network cost-sharing (deductibles, co-payments, and co-insurance) for the following services performed by an OON provider:

- Emergency services provided in an emergency department of a hospital (including a hospital outpatient department) and in a freestanding emergency department. Rules similar to the ACA requirements for emergency services also apply. If a plan covers any benefits for services in an emergency department of a hospital (including a hospital outpatient department) or emergency services in a freestanding emergency department: (1) plans cannot impose prior authorization requirements on emergency services (whether in-network or OON); (2) plans must cover emergency services even if the provider or facility is OON; (3) if the services are provided by an OON provider or facility, the plan cannot impose any requirement for prior authorization or any limitation on coverage that is more restrictive than the requirements that apply to in-network emergency services; and (4) plans must cover emergency services without regard to any other term of condition of coverage, other than exclusion or coordination of benefits or a permitted affiliation or waiting period.
- Ancillary services provided by an OON provider at an in-network facility. Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether or not provided by a physician or non-physician practitioner); items and services provided by assistant surgeons, hospitalists, and intensivists; and diagnostic services (including radiology and laboratory services). In addition, items and services provided by an OON provider are considered ancillary if there is no in-network provider that can furnish the service at the facility. Regulations may add additional items and services that are ancillary and may also provide a list of advanced diagnostic laboratory tests that are not ancillary services.
- Non-emergency services performed by an OON provider at an in-network facility, unless the provider has complied with notice requirements and the individual consents to using the OON provider. The exception for complying with notice and consent requirements does not apply to ancillary services or to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time a covered item or service is furnished.

Plans must count participant cost-sharing for these OON services in the same manner as in-network cost-sharing (e.g., counting the cost-sharing against any in-network deductible or out-of-pocket amount). In applying the plan's in-network cost-sharing provisions to these OON services, the "recognized amount" is treated as the amount that would have been charged by an in-network provider. For example, if a plan's cost-sharing rate for an in-network service is 20%, then if the service is performed by an OON provider, the cost-sharing amount would be 20% multiplied by the recognized amount.

In general, the recognized amount is one of the following three amounts: (1) the amount determined by an applicable state law (e.g., for a fully insured plan); (2) if there is no applicable state law (e.g., in the case of a self-funded plan subject to ERISA), the "qualifying payment amount," which is based on median contracted rates recognized by the plan; or (3) in the case of a state that has an all-payer model agreement in effect with the Centers for Medicare and Medicaid Services (CMS) pursuant to Section 1115A of the Social Security Act, the amount the state approves for the item or service.

Providers are prohibited from balance billing plan participants for any amount exceeding the in-network cost-sharing for the these OON services. Group health plans are required to make an initial payment to the OON provider or a notice of denial of payment within 30 calendar days after receiving a bill from the provider.

The legislation specifically provides that the provisions relating to surprise medical bills do not impact HSA eligibility.

Dispute Resolution Process Between Providers and Health Plans

A number of states already have laws that protect participants from surprise medical bills from fully insured plans. The No Surprises Act defers to payment amounts for surprise medical bills as determined under applicable state law. If such a state law does not apply (e.g., in the case self-funded plans subject to ERISA), bills will be resolved under an independent dispute resolution (IDR) arbitration process.

Under the IDR process, plans and providers may negotiate during a 30-day cooling-off period, which starts on the date the provider receives the initial payment or notice of denial. If a settlement is not reached during this period, either party may initiate the IDR process within four days of the end of the cooling-off period. Providers may bundle payments to be considered in the IDR process. There is no dollar threshold for claims to be submitted to arbitration, so claims of any amount may be submitted. The IDR process is "baseball style" arbitration, meaning that each party provides a payment offer and the arbitrator must choose one of the offers. The losing party pays the cost of arbitration. If the provider and plan agree to a payment amount before the IDR entity makes its decision, costs are split between the parties.

In general, the IDR arbitrator can consider any factors submitted by either party in making its decision. There are, however, certain factors the arbitrator can and cannot consider. For example, the arbitrator is to consider the qualified payment amount as well as information relating to the level of training, experience, and quality of outcomes of the provider, the market share held by the provider, the acuity of the individual receiving the service, and the teaching status, case mix, and scope of services of the OON facility where the services were performed. Importantly, the IDR arbitrator cannot consider the provider's billed charges or reimbursement rates from public payors, including Medicare and Medicaid.

The IDR arbitrator has 30 days to make a decision. The decision is binding on the parities (except in the case of fraud or misrepresentation of facts). The decision also is not subject to judicial review, except in limited circumstances such as fraud, partiality, or corruption on the part of the arbitrator, misconduct on the part of the arbitrator, or if the arbitrator exceeded its powers. Following the decision, the party that initiated arbitration cannot request arbitration for similar claims for a "lock-out" period of 90 days. This waiting period is intended to provide some incentive for the parties to negotiate similar claims. Claims relating to the lock-out period may, however, be submitted after the lock-out period ends.

Ambulance Services

Rules similar to the surprise billing provisions also apply to air ambulance services. There are some differences; for example, the factors the IDR reviewer are to consider are somewhat different in the case of air ambulance services.

Ground ambulance services are not subject to the surprise billing provisions. Instead, the CAA directs the Secretaries of Labor, Treasury, and HHS to establish an advisory committee on ground ambulance services and patient billing. The committee is to submit its report and recommendations to Congress within 180 days after the committee's first meeting.

Additional Provisions, Including Transparency Requirements

Access to external review process for surprise medical bills

The ACA external review process is extended to cover issues relating to surprise medical bills, including whether a particular item or service is subject to new surprise billing rules. Note that the external review process does not apply to grandfathered plans, so that such plans should not be subject to this new requirement. Clarification on this point from federal regulators would be helpful. The tri-agencies are directed to implement this provision not later than January 1, 2022.

Continuity of care

When a provider leaves a plan's network, individuals in certain circumstances must be provided 90 days of continuing care as if the provider were still in-network. This applies if an individual is undergoing a course of treatment for a serious and complex condition; undergoing a course of institutional or inpatient care; scheduled to undergo nonelective surgery, including postoperative care; is pregnant and undergoing a course of treatment for the pregnancy; or was determined to be terminally ill. It is unclear whether this provision applies to grandfather plans.

Disclosure and transparency rules

A number of new disclosure and transparency provisions are imposed on group health plans, including:

- Provide an advanced explanation of benefits before scheduled care, including information such as the estimates of cost-sharing and the amount the plan will pay for the service and whether the provider is in-network or OON.
- Maintain price comparison tools available online and over the phone.
- Maintain up-to-date provider directories.
- Include in-network and OON deductibles and out-of-pocket maximums on health plan member electronic or physical identification cards.

Providers are also subject to disclosure requirements, including a requirement for OON providers to provide a "good faith estimated amount" for all services to be provided.

All-payer claims database

Funding is provided for states to establish or expand all-payer claims databases.

Enforcement

The surprise billing and related provisions applicable to group health plans are added to the Code, PHSA, and ERISA and will be subject to the same general enforcement structure as the ACA coverage mandates. States retain primary enforcement authority over fully insured plans, subject to federal enforcement by HHS if a state fails to substantially enforce a provision. HHS also has jurisdiction over self-funded governmental plans. The DOL has enforcement authority over plans subject to ERISA. Under the Code, a $100 per day excise tax may apply in the case of noncompliance by private sector plans and church plans. Provisions applicable to providers are added to the PHSA and are subject to primary enforcement at the state level and potential federal enforcement. The DOL is specifically authorized to coordinate with states and HHS regarding violations of provider requirements for group health plans and conduct investigations as appropriate.

You can subscribe to future ***Employee Benefits & Executive Compensation*** advisories and other Alston & Bird publications by completing our **publications subscription form**.

If you have any questions or would like additional information, please contact your Alston & Bird attorney or any of the following:

Members of Alston & Bird's Employee Benefits & Executive Compensation Group

Emily Seymour Costin
202.239.3695
emily.costin@alston.com

R. Blake Crohan
404.881.4625
blake.crohan@alston.com

Meredith Gage
404.881.7953
meredith.gage@alston.com

Ashley Gillihan
404.881.7390
ashley.gillihan@alston.com

David R. Godofsky
202.239.3392
david.godofsky@alston.com

Amy Heppner
404.881.7846
amy.heppner@alston.com

John R. Hickman
404.881.7885
john.hickman@alston.com

H. Douglas Hinson
404.881.7590
doug.hinson@alston.com

James S. Hutchinson
212.210.9552
jamie.hutchinson@alston.com

Michelle Jackson
404.881.7870
michelle.jackson@alston.com

Kenneth M. Johnson
919.862.2290
kenneth.johnson@alston.com

Edward T. Kang
202.239.3728
edward.kang@alston.com

Blake Calvin MacKay
404.881.4982
blake.mackay@alston.com

Earl Pomeroy
202.239.3835
earl.pomeroy@alston.com

Earl Porter
404.881.7135
earl.porter@alston.com

Cremeithius M. Riggins
404.881.4595
cremeithius.riggins@alston.com

Jonathan G. Rose
202.239.3693
jonathan.rose@alston.com

Syed Fahad Saghir
202.239.3220
fahad.saghir@alston.com

John B. Shannon
404.881.7466
john.shannon@alston.com

Carolyn E. Smith
202.239.3566
carolyn.smith@alston.com

Michael L. Stevens
404.881.7970
mike.stevens@alston.com

Kerry T. Wenzel
404.881.4983
kerry.wenzel@alston.com

Kyle R. Woods
404.881.7525
kyle.woods@alston.com

ALSTON & BIRD

WWW.ALSTON.COM

ATLANTA: One Atlantic Center ■ 1201 West Peachtree Street ■ Atlanta, Georgia, USA, 30309-3424 ■ 404.881.7000 ■ Fax: 404.881.7777
BEIJING: Hanwei Plaza West Wing ■ Suite 21B2 ■ No. 7 Guanghua Road ■ Chaoyang District ■ Beijing, 100004 CN ■ +86 10 8592 7500
BRUSSELS: Level 20 Bastion Tower ■ Place du Champ de Mars ■ B-1050 Brussels, BE ■ +32 2 550 3700 ■ Fax: +32 2 550 3719
CHARLOTTE: Bank of America Plaza ■ 101 South Tryon Street ■ Suite 4000 ■ Charlotte, North Carolina, USA, 28280-4000 ■ 704.444.1000 ■ Fax: 704.444.111
DALLAS: Chase Tower ■ 2200 Ross Avenue ■ Suite 2300 ■ Dallas, Texas, USA, 75201 ■ 214.922.3400 ■ Fax: 214.922.3899
FORT WORTH: 3700 Hulen Street ■ Building 3 ■ Suite 150 ■ Fort Worth, Texas, USA, 76107 ■ 214.922.3400 ■ Fax: 214.922.3899
LONDON: 5th Floor, Octagon Point, St. Paul's ■ 5 Cheapside ■ London, EC2V 6AA, UK ■ +44.0.20.3823.2225
LOS ANGELES: 333 South Hope Street ■ 16th Floor ■ Los Angeles, California, USA, 90071-3004 ■ 213.576.1000 ■ Fax: 213.576.1100
NEW YORK: 90 Park Avenue ■ 15th Floor ■ New York, New York, USA, 10016-1387 ■ 212.210.9400 ■ Fax: 212.210.9444
RALEIGH: 555 Fayetteville Street ■ Suite 600 ■ Raleigh, North Carolina, USA, 27601-3034 ■ 919.862.2200 ■ Fax: 919.862.2260
SAN FRANCISCO: 560 Mission Street ■ Suite 2100 ■ San Francisco, California, USA, 94105-0912 ■ 415.243.1000 ■ Fax: 415.243.1001
SILICON VALLEY: 950 Page Mill Road ■ Palo Alto, California, USA 94304-1012 ■ 650.838.2000 ■ Fax: 650.838.2001
WASHINGTON, DC: The Atlantic Building ■ 950 F Street, NW ■ Washington, DC, USA, 20004-1404 ■ 202.239.3300 ■ Fax: 202.239.3333