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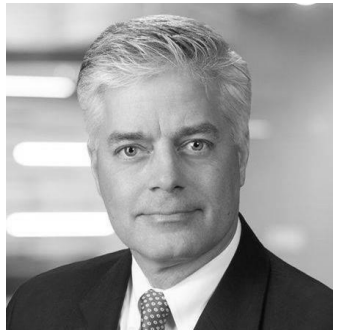


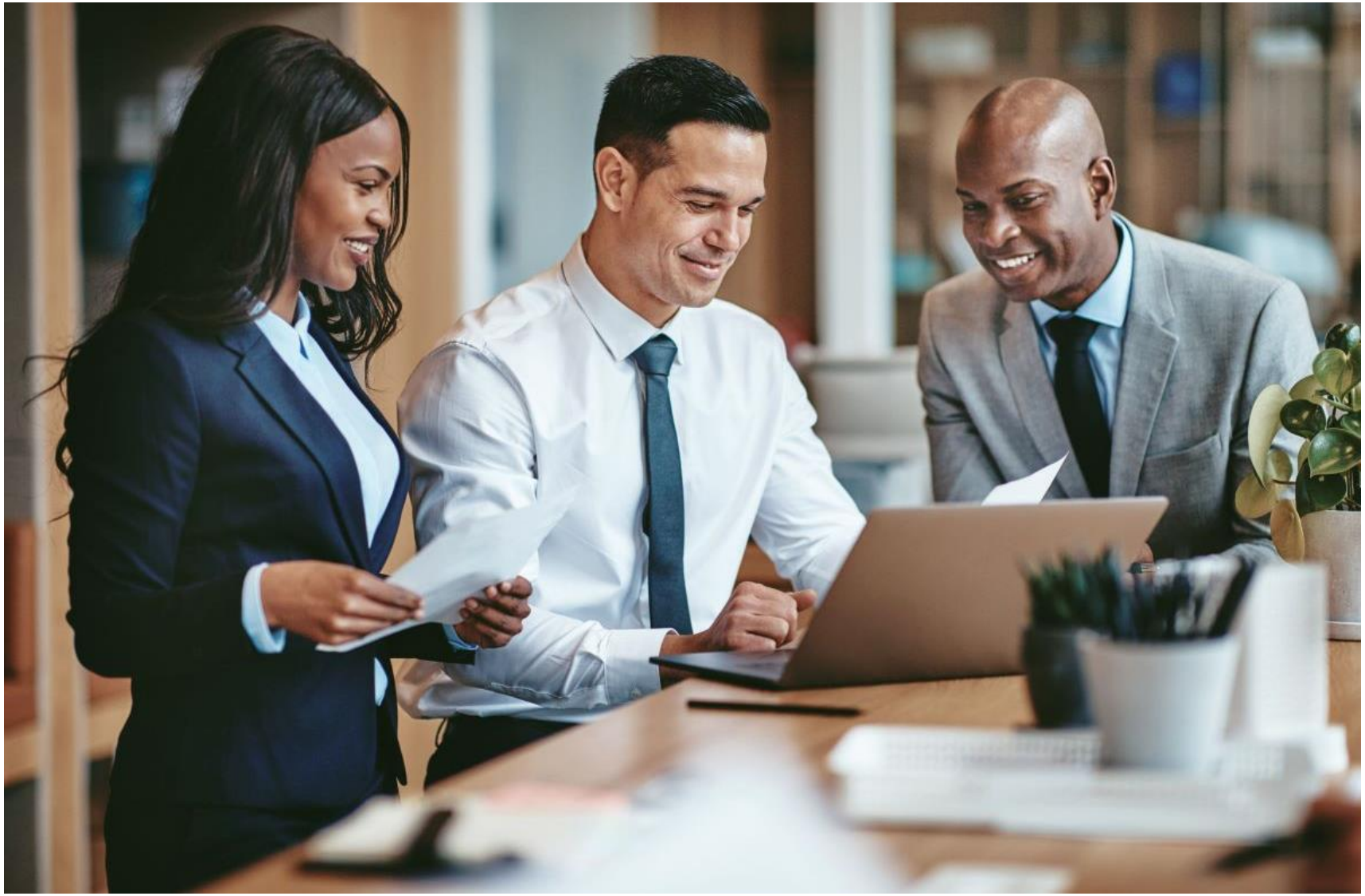
Presented by Fisher Phillips

Carlton C. Pilger

Of Counsel

Please remember, employment and benefits law compliance depends on multiple factors – particularly those unique to each employer's circumstances. Numerous laws, regulations, interpretations, administrative rulings, court decisions, and other authorities must be specifically evaluated in applying the topics covered by this webinar. The webinar is intended for general-information purposes only. It is not a comprehensive or all-inclusive explanation of the topics or concepts covered by the webinar.

2022 And 2023 Transparency In Action



Agenda

Transparency in Coverage Rules

- Machine-Readable Files (MRF)
- Rx/Healthcare Spending and Reporting
- Price Transparency Tool
- ID Cards & Provider Directories
- Good Faith Estimate & Advanced EOBs
- Gag Clause Prohibitions

Agenda

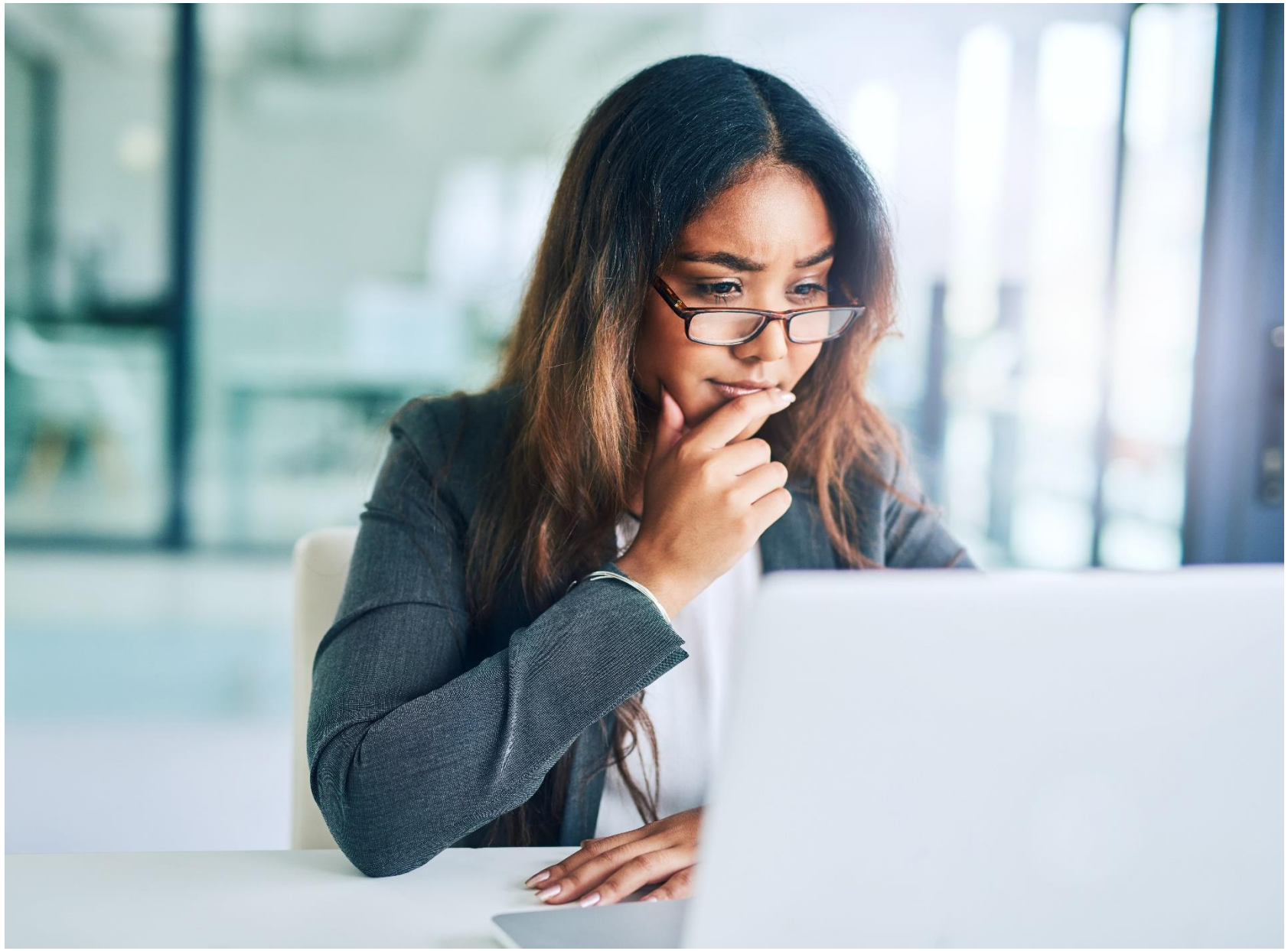
Mental Health Parity and Addiction Equity Act (MHPAEA)

- Non-quantitative Treatment Limitation (NQTL) Analyses

Key Takeaways

- Employer responsibilities
- Potential fiduciary duty impact
- Potential cost impact
- Changing independent dispute resolution (IDR) process
- Non-compliance consequences

Transparency in Coverage Rules



Transparency in Coverage Rules

- Rules encompass provisions from both Affordable Care Act (ACA) and Consolidated Appropriations Act, 2021 (CAA)
- Generally apply to all non-grandfathered plans whether self-funded or insured and regardless of size
- Following types of plans and coverage not subject to final rules:
  - grandfathered plans;
  - excepted benefits (e.g., most EAPs, dental, vision);
  - health care sharing ministries;
  - short-term, limited-duration insurance; or
  - account-based health plans (FSAs, HSAs, and HRAs, including ICHRAs and QSEHRAs)

- Machine-Readable Files (MRF)
  - Mandated as of July 1, 2022 for general health care information
  - Delayed for Rx information (no updated due date)
  - Most recent guidance states carrier posting to website will suffice
- Rx Drug/Health Care Spending Reporting
  - Report required to be filed annually with Centers for Medicare & Medicaid Services (CMS)
  - First report due December 27, 2022 (covering 2020 and 2021)
  - Thereafter file by June 1 following calendar year reported (i.e., June 1, 2023 to report 2022)
  - Plans can require carrier or TPA to file, but will remain liable if third party fails

- Rx Drug/Health Care Spending Reporting
  - Report will be filed through CMS Health Insurance Oversight System (HIOS)
    - Coordinate with carrier or vendor who already has HIOS access; Otherwise will need to apply for own credentials
  - General plan information required
  - Identify 50 most-dispensed, most-costly, and greatest YTY increase Rx drugs
  - Plan spending info
  - Premium info (no enforcement for first report if data supplied on next required report)

Machine Readable Files

- Big Picture: beginning 7/1/2022 – GHPs/Issuers must publish, for public viewing and access, machine-readable files showing plan design information including negotiated rates and historical allowed amounts for out-of-network providers
- Penalty structure and safe harbors are the same for the public disclosure rule (ACA - $100 per day, per person, per violation)
  - Fully-insured plan sponsors can contract away liability to issuer, but not self-insured plan sponsors
  - However, "Good Faith Compliance Safe Harbor" also applies

Disclosure Requirements:

- Disclosure must be available on an internet website to the public without requiring access credentials
- Must include three machine-readable files showing:
  - an in-network rate file
  - an out-of-network allowed amount file
  - a prescription drug machine-readable file. (Delayed)
- "Machine readable" means non-proprietary open format 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 (e.g. no PDF files due to its proprietary nature).

1. The In-Network Machine Readable File must include:

   a) For each coverage option offered by a plan or insurer:

   - Identifier
     - name and 14-digit HIOS identifier (if one is available),
     - 5-digit HIOS identifier (if the 14-digit is not available)
     - EIN if no HIOS identifier is available.
   - Billing code used by the plan or insurer to identify items or services (e.g., CPT Code, HCPCS code, DRG, or NDC).
   - Plain language description for each billing code.
   - All applicable rates.

2. The Allowed Amount Machine Readable File must include:

a) For each coverage option offered by a plan or insurer:

- Identifier
  - name and 14-digit HIOS identifier (if one is available),
  - 5-digit HIOS identifier (if the 14-digit is not available)
  - EIN if no HIOS identifier is available.
- Billing code used by the plan or insurer to identify items or services (e.g., CPT Code, HCPCS code, DRG, or NDC)
- Plain language description for each billing code.

c) Unique out-of-network allowed amounts and billed charges of out-of-network providers.
   - For period that begins 180 days prior to publishing file (but plan or insurer must omit if out-of-network allowed amounts in connection with fewer than 20 different claims under a single plan or coverage).
   - Stated as a dollar amount with respect to the covered item or service furnished by an out-of-network provider, and associated with the NPI, TIN or Plan of Service Code for each out-of-network provider.

d) Historical data showing allowed amounts and billed charges (i.e., balance bills) for covered items and services, including prescription drugs, furnished by out-of-network providers for which the plan or issuer has adjudicated the claims.

3. The Prescription Drug Machine Readable File must include:

a) For each coverage option offered by a plan or insurer:

- Identifier
  - name and 14-digit HIOS identifier (if one is available),
  - 5-digit HIOS identifier (if the 14-digit is not available)
  - EIN if no HIOS identifier is available.
- Billing code used by the plan or insurer to identify items or services (e.g., CPT Code, HCPCS code, DRG, or NDC)
- Plain language description for each billing code.

c) Negotiated rates and historical net prices.

Current Effective Dates

- Public Disclosure of Negotiated Rates and Historical Allowed Amounts: July 1, 2022
- Public Disclosure of Prescription Drug Info: TBD
- Disclosure of Cost Information – January 1, 2023 and January 1, 2024

Required Disclosures

1. Estimated cost-sharing liability – The amount a health coverage recipient is responsible for paying for a covered item or service
    - deductibles
    - coinsurance requirements
    - copayments.
- Plans and issuers should provide one overall cost-sharing liability estimate for a bundled payment arrangement if that is the only cost sharing
- Preventive vs. non-preventive
    - plan or issuer must display the non-preventive cost sharing liability along with a statement may not be subject to cost-sharing if it is billed as a preventive service.

2. Accumulated amounts

- The amount of financial responsibility that a health coverage recipient has incurred at the time the request for cost-sharing information is made (deductible and/or an OOP)
  - Individual vs. Family
  - Must include amounts accrued toward non-dollar limits such as days, units, or visits.

3. In-network rates – The amount a plan or issuer has contractually agreed to pay for a covered item or service, whether directly or indirectly through a TPA or pharmacy benefit manager (PBM), to an in-network provider, including an in-network pharmacy or other prescription drug dispenser, for covered items or services.
   - Underlying fee schedule rate if different from the negotiated rate.
   - N/A for plans with no negotiated rates or underlying fee schedule rates (for example plans or issues using alternative reimbursement models, such as a capitated or bundled payment arrangements)
   - For Rx drugs, plans and issuers must disclose: (1) an individual's out-of-pocket cost liability for prescription drugs, and (2) the negotiated rate of the drug.

4. Out-of-network allowed amount – The maximum amount (or method to calculate) what the plan will pay an out-of-network provider – must include cost-sharing liability for the health coverage recipient.
5. Items and services content list – A list of those covered items and services for which cost-sharing information is disclosed.
6. Notice of prerequisites to coverage – A notice informing the individual, when applicable, that a specific covered item or service for which the individual requests cost-sharing information may be subject to a prerequisite for coverage.

7. Disclosure notice – 5 specific disclaimers:
   - Balance billing may apply
   - Actual charges may be different
   - Estimate is not a guarantee of coverage for items and services
   - Whether plan counts copayment assistance/third-party payments in the calculation of the deductible and out-of-pocket maximum
   - Preventive care may or may not be subject to cost-sharing depending on how billed by provider
   - Permitted to include additional information if not in conflict with the information required to be provided in the notice

Required Methods for Disclosure

The cost-sharing information described above must be disclosed without a fee using two methods:

1) an internet-based self-service tool, and
2) in paper form if requested.

Disclosure via Internet-Based Self-Service Tool - Requirements

- Allow users to:
  - search for real-time accurate cost-sharing information for covered items and services provided by a specific in-network provider, or by all in-network providers.
  - search for the out-of-network allowed amount for a covered item or service provided by out-of-network providers.
  - refine and reorder search results based on geographic proximity of in-network providers

Disclosure via Internet-Based Self-Service Tool Requirements

- Allow users to:
  - search for cost-sharing information by billing code or by descriptive term, or by a specific in-network provider's name in conjunction with a billing code or descriptive term.
  - produce the relevant cost-sharing information for the covered item or service for each tier for multi-tiered network.
  - input variables and receive estimates if cost-sharing is based on factors other than provider (e.g., a specific facility or Rx dosage)

Disclosure via Paper Requirements

- Paper copies of the cost-sharing information under the internet tool must be available upon request.
- Mailed to the requesting health coverage recipient within two (2) business days
- If request returns more than one result, the participant can request that it be refined and reordered by geographic proximity and cost-sharing liability estimates
- May limit to 20 providers per request.
- With agreement of requesting individual, this "paper" disclosure may be satisfied by communication via phone or e-mail within same time frame

Effective Dates for Coverage Disclosures

- January 1, 2023
  - Estimated cost-sharing information in plain language for 500 covered items or services listed in Table 1 of the final rule (includes prescription drugs and durable medical equipment)
- January 1, 2024
  - Estimated cost-sharing information in plain language for all covered items or services regardless of whether listed in Table 1

Responsibility for Disclosure

- Penalty structure same as ACA ($100 per person, per day, per violation) and responsibility of GHP/employer
- Fully-Insured GHPs – Sponsor may contract with issuer and shift responsibility for penalty under final rule ("fully-insured safe harbor")
- Third-Party Contracts - Sponsor of self-insured GHP or an issuer may contract with third party (e.g., PBM for Rx), but cannot shift responsibility under final rule
    - Contract terms are key to protecting sponsor

Good Faith Compliance Safe Harbor

- A plan or issuer will not fail to comply with the final rules described above, if acting in good faith and with reasonable diligence, the plan or issuer makes an error or omission in a disclosure, provided that the information is corrected as soon as practicable.
- To the extent such error or omission is due to good faith reliance on information from another entity, the final rules include a special applicability provision that holds the plan or issuer harmless, unless the plan or issuer knows, or reasonably should have known, that the information is incomplete or inaccurate.
- A plan or issuer will not violate the final rules solely because, despite acting in good faith and with reasonable diligence, its Internet website is temporarily inaccessible, provided that the plan or issuer makes the information available as soon as practicable.

Gag Clause Prohibition

- Health plan may not enter into agreement with TPA or other provider or network of providers that restricts the plan from providing provider-specific information on costs or quality of care, getting electronic access to de-identified participant data, or sharing information with business associate(s).
- Attestations required annually; no form attestation available yet.
- DOL, HHS and IRS enforcement; Could be subject to ACA fine of $100/day/individual
- Review contracts and amend as needed.

ID Card Information

- Plan ID cards must contain clear details regarding deductibles and OOP maximums.
- Must also include telephone number and web address to obtain further information.
- Good faith compliance sufficient; guidance states QR code or hyperlink on digital ID card could make information available on web site.
- DOL, HHS and IRS enforcement; Could be subject to ACA fine of $100/day/individual
- Make sure carriers and TPAs follow rules.

Provider Directories

- Must maintain updated directories on public web site with specific provider information.
- Information must be regularly updated (at least every 90 days); refer to web site in any printed directory with admonition that most current information is on web site.
- Participants will get in-network coverage for out-of-network provider(s) if directory information misled them as to providers network status
- Good faith compliance sufficient.
- DOL, HHS and IRS enforcement; Could be subject to ACA fine of $100/day/individual
- Make sure carriers and TPAs follow rules.
- Provide link to website where information published.

Continuity of Care

- Participants must have opportunity to choose transitional period of ongoing care when provider network status changes.
- Care to be provided at same rate before network termination.
- Applies to serious conditions, terminal illness, pregnancy, inpatient care and scheduled surgeries.
- Plan must provide notice of transitional period which will last 90 days from notice.
- Good faith compliance sufficient.
- DOL, HHS and IRS enforcement; Could be subject to ACA fine of $100/day/individual.

Independent Dispute Resolution

- No Surprises Act required a formal independent dispute resolution process for out-of-network claims and expenses.
- When payer and provider do not come to terms, referred to binding arbitration to IDR entity.
- Original rules required IDR entity to choose offer closest to qualified payment amount (QPA) (i.e., insurance plan's median contracted rate for same service in similar area) absent sufficient evidence that QPA materially off.
- New rules remove QPA presumption and requires disclosure of any downcoding.
- IDR entity must provide detailed payment explanation.

MHPAEA

Mental Health Parity & Addiction Equity Act Comparative analyses

- Focus on non-quantitative treatment limits (NQTL)
- Should ensure that carrier or TPA are doing what needs to be done; if not will need a solution
- Consider establishing a health & welfare plan committee; also will help in other areas of compliance
- *Raytheon* case recently decided in 1st Circuit highlights importance of having analysis documented

Mental Health Parity & Addiction Equity Act

- NQTL comparative analyses
- DOL 2022 Report to Congress declares EBSA and HHS will step up enforcement with "all available resources"
- Report states that zero of 156 NQTL analyses reviewed were compliant and listed common failures
- Failure to document comparative analysis before designing and applying the NQTL

Mental Health Parity & Addiction Equity Act

- NQTL comparative analysis common failures
  - Conclusory assertions lacking specific supporting evidence or detailed explanation;
  - Lack of meaningful comparison or meaningful analysis;
  - Non-responsive comparative analysis;
  - Documents provided without adequate explanation;
  - Failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classification affected by an NQTL;
  - Limiting scope of analysis to only a portion of the NQTL at issue; and
  - Failure to demonstrate compliance of an NQTL as applied.

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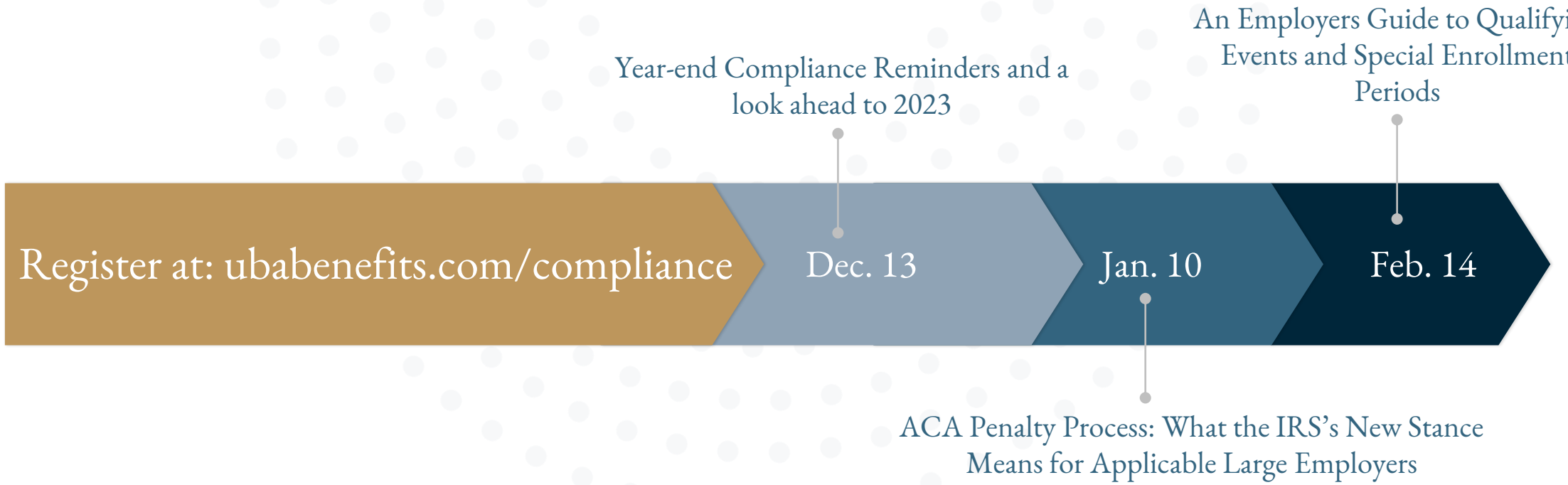

Thank You