Open Enrollment Season is the Perfect Time to Align Group Health Plans with New Legislative and Regulatory Requirements

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Every fall, employers offering group welfare benefit plans with plan years on a calendar year basis start to turn their attention to renewing benefit offerings for the upcoming plan year. Plan administrators typically use this period to update plan documents and summary plan descriptions, distribute annual notices, and conduct nondiscrimination testing. Of course, the COVID-19 pandemic has necessitated the modification of notice timing rules which group health plan administrators must continue to honor, as discussed in a prior client alert: resources-alerts-US-Department-of-Labor-Further-Extends-Certain-Employee-Benefit-Deadlines-due-to-COVID-19.html.

This year, open enrollment carries additional importance due to the recent onslaught of legislative and regulatory changes impacting group health plans. We have addressed the changes in two previous client alerts: first with respect to new price transparency disclosure rules (resources-alerts-Federal-Agencies-Finalize-Price-Transparency-Disclosure-Rules-under-Affordable-Care-Act.html); and second with respect to the multitude of new group health plan requirements packed into the Consolidated Appropriations Act of 2021 (resources-alerts-More-Changes-for-Employee-Benefit-Plans-for-2021.html). As a result, plan administrators of self-funded and insured group health plans might want to take this opportunity during Fall 2021 to align their group health plans with the following:

Service Provider Disclosures

Certain group health plans either entering into or renewing contracts with brokers or consultants as of December 27, 2021 will need to receive a disclosure as to the direct and indirect compensation received by the broker or consultant, if the broker or consultant reasonably expects $1,000 or more in compensation. Any type of group health plan that pays compensation to a broker or consultant should receive a

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disclosure. While regulations may clarify the scope of the requirement, at this time should a broker or consultant receive fees entirely from a plan sponsor, no disclosure is likely necessary. If a disclosure is not issued, but should have been, group health plan administrators will have an affirmative obligation to request the disclosure, and then report to the Department of Labor if a disclosure is still not issued.

Coverage Transparency - Public Price Information

Non-grandfathered self-funded group health plans and group health insurance issuers will need to comply with the first regulatory requirement issued by the Departments of Labor, Treasury, and Health & Human Services (collectively, the "Federal Agencies") pertaining to coverage transparency by making available on a public internet website three machine readable files of price information. The three machine readable files will consist of in-network rates, out-of-network allowed amounts and billed charges, and prescription drug pricing.

While the final regulations with respect to the machine-readable files take effect for plan years beginning on or after January 1, 2022, the Federal Agencies deferred enforcement of the disclosures on August 20, 2021. Specifically, the Federal Agencies will defer enforcement with respect to the first two types of machine-readable files until July 1, 2022 and will defer enforcement on the third machine readable file pertaining to prescription drug pricing until the release of further rulemaking.

The "coverage transparency" rules do not apply to certain group health plans, such as grandfathered plans, limited-scope dental and vision benefits, health flexible spending accounts, and retiree-only plans. As a result, plan administrators of covered self-funded group health plans should contact their medical and prescription drug administrative service providers to create a timeline for implementation of the disclosure rules while also revisiting contracts to make necessary revisions to address the new obligations. Plan administrators of insured group health plans can enter into an agreement with the medical and prescription drug insurance issuer where the issuer will disclose the required information and ultimately be liable for any failure to disclose.

Please note the second requirement of the transparency in coverage rules (the out-of-pocket estimator) does not take effect until 2023. However, plan administrators ought to take the time now to inquire with medical and prescription drug administrative service providers and insurance carriers as to strides taken towards compliance.

Comparative Assessment of Non-Quantitative Treatment Limitations

Self-funded group health plans and group health insurance issuers (except in limited instances such as limited-scope dental and vision benefits, health flexible spending accounts, and retiree-only plans) must now have an assessment "at the ready" comparing the non-quantitative treatment limitations of the mental health/substance use disorder benefits of the plan to the medical/surgical benefits of the plan. The assessment must be disclosed to the Department of Labor within 45 days upon request. Plan administrators of self-funded group health plans should contact their medical and prescription drug administrative service providers to request assistance with completing the comparative analysis (or alternatively use the Department of Labor self-compliance tool to complete the analysis

in-house). Plan administrators of insured group health plans should confirm the health insurance issuer has completed the comparative analysis and request a copy for plan records.

Elimination of Gag Clauses on Price and Quality Information

Self-funded group medical plans and group medical insurance issuers are now prohibited from entering into a contract that directly or indirectly restricts certain acts. First, such agreements may not restrict the ability to distribute provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or individuals otherwise eligible to become participants or beneficiaries. Second, such agreements may not restrict the electronic access of de-identified claims and encounter information. Finally, such agreements may not restrict the sharing information or data with a HIPAA business associate. Plans and issuers are required to file attestations of compliance with these requirements, which the Federal Agencies anticipate collecting starting in 2022.

The rule eliminating gag clauses does not apply to certain medical plans, such as health flexible spending accounts and retiree-only plans. As a result, plan administrators of self-funded group medical plans should contact their medical administrative service providers to update benefit certificates and administrative contracts where necessary and be prepared to make attestations once the Federal Agencies are ready to accept. Plan administrators of insured group health plans should confirm the medical insurance policy is updated and attestations are appropriately made (and request copies for plan records).

Annual Report on Pharmacy Benefits and Drug Costs

Self-funded group prescription drug plans and group prescription drug insurance issuers must submit an annual report to the Federal Agencies on the prescription drug benefits and costs offered by the plan. This rule is generally effective December 27, 2021, but on August 20, 2021 the Federal Agencies deferred enforcement until the issuance of final regulations.

The reporting rule does not apply to certain prescription drug plans, such as health flexible spending accounts and retiree-only plan. As a result, plan administrators of covered self-funded group prescription drug plans should contact their prescription drug administrative service providers to update administrative contracts where necessary to ensure the administrative service provider will assist the plan administrator with meeting reporting requirements. Plan administrators of covered insured group prescription drug plans should confirm the prescription drug insurance policy is updated (and request copies for plan records, including copies of the annual report once filed).

"No Surprises Act" Compliance

Primarily starting on January 1, 2022, self-funded group health plans and group health insurance issuers must comply with a multitude of rules designed to protect participants and beneficiaries from unknown medical costs, such as:

- Mandates restricting "surprise" medical bills, particularly related to emergency and air ambulance services;
- Issuing updated medical and prescription drug insurance cards disclosing applicable deductible or out-of-pocket maximum limitations;
- Issuing advanced explanation of benefits for scheduled medical services (on August 20, 2021, the Federal Agencies deferred enforcement of this requirement until the issuance of final regulations);
- Notifying continuing care patients of changes in network status;
- Maintaining a cost-sharing medical and prescription drug price comparison tool via website and offering price comparison guidance over the telephone (on August 20, 2021, the Federal Agencies deferred enforcement of this requirement until plan years beginning on and after January 1, 2023); and
- Maintaining up-to-date provider directories and issuing balance billing disclosures.

The "No Surprises Act" rules do not apply to certain health plans, such as health flexible spending accounts and retiree-only plans. As a result, plan administrators of self-funded group health plans should contact their medical and prescription drug administrative service providers to update benefit certificates and administrative contracts where necessary to ensure compliance, while confirming notices/disclosures will be issued. Plan administrators of insured group health plans should confirm the medical and prescription drug insurance policy is updated (and request copies for plan records) and that notices/disclosures will be issued. In either case, plan administrators should revisit plan documents to coordinate provisions with the surprise billing and continuity of care requirements.

Please contact your Employee Benefits attorney at Butzel Long, or the author of this message, if you would like help in ensuring compliance with these new legal requirements.

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