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In this Issue:

New Group Health Plan Requirements Now in Effect

Several significant new requirements for group health plans that were enacted as part of the Consolidated Appropriations Act (CAA), 2020 – including the Surprise

Billing rules – are now in effect. The new health plan transparency regulations are also now partially in effect.

Background

As discussed in Rewards Policy Insider 2021-3, the new "surprise billing" rules are designed to prevent people with insurance from being balance billed by out-of-network providers or facilities in certain circumstances. In particular, the rules apply when a participant receives emergency services or air ambulance services from an out-of-network provider or facility. But they also can apply when a participant receives non-emergency services from an out-of-network provider in a network facility.

When the surprise billing rules apply, plans (both fully insured and self-insured) must treat the participant as if the relevant services were provided in-network. As such, they must apply in-network cost-sharing requirements, and any required cost-sharing must be applied against the plan's applicable in-network deductible and out-of-pocket maximum. The plan also must follow specific rules for resolving disputes with out-of-network providers about how much the plan is required to pay them.

In addition to these rules, plans are subject to the following for plan years beginning on or after January 1, 2022:

- Plan ID Cards: Physical and electronic ID cards must include information about applicable deductibles and out-of-pocket maximums, plus information about gaining access to consumer assistance.
- Fair and Honest Advance Cost Estimate: Plans must provide advance estimates of a participant's out-of-pocket costs for scheduled items or services. In many cases, the estimate will have to be provided in as little as one business day. Note that the agencies have deferred enforcement of this requirement until additional guidance is issued.
- Continuity of Care: Plans must allow certain participants receiving services from participating providers or facilities to continue under the same terms and conditions for a limited period of time even if the provider's or facility's status changes.
- Provider Directory Information: Plans must maintain an up-to-date list of participating providers and facilities on their public websites. If a participant receives misleading information from the directory and receives services from a non-participating provider and/or at a non-participating facility as a result, then the participant must be treated as if they used a participating provider or facility.

Plans also face new reporting requirements relating to their prescription drug benefits. Under this rule, group health plans must annually report to the Secretaries of Labor and Treasury the following information relating to the health plan for the previous year:

- The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan, and the total number of paid claims for each drug;
- The 50 most costly prescription drugs with respect to the plan by total annual spending, and the annual amount spent by the plan for each such drug;
- The 50 prescription drugs with the greatest year over year increase in plan expenditures, with a specific year over year change for each such drug;

- The plan's total spending on health care services, broken down by –
    - The type of costs, including hospitals, health care providers and clinical services, prescription drugs, and other medical costs
    - Spending on prescription drugs by the health plan and enrollees
- The average monthly premium, including the share paid by the employer and by employees; and
- If drug manufacturers pay any rebates, fees, and other payments to the plan, its administrators, or service providers, with respect to prescription drugs prescribed to enrollees, the impact of those payments on premiums and out-of-pocket costs.

The initial reports will cover 2020 and 2021 and must be filed by December 27, 2022. The report for 2022 will be due on June 1, 2023, and June 1 will be the deadline for annual reports going forward. (Note that the initial reports were supposed to be due by December 27, 2021 for 2020, and by June 1, 2022 for 2021. The agencies exercised enforcement discretion to defer the reporting deadline for 2020 and 2021 to December 27, 2022).

Health Plan Transparency Regulations

As noted, the health plan transparency regulations also started to take effect for plan years beginning on or after January 1, 2022. Briefly, under these rules, group health plans must:

- Make available on a public website three separate machine-readable files with the following information:
    - negotiated rates for all covered items and services between the plan or issuer and in-network providers;
    - historical payments to, and billed charges from, out-of-network providers; and
    - in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level; and
- make available to participants, beneficiaries, and enrollees (or their authorized representative) personalized out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services, including prescription drugs, through an internet-based self-service tool and in paper form upon request.

Enforcement of the requirement to post the machine-readable file relating to prescription drugs has been deferred indefinitely. Among other things, regulators are considering whether this particular requirement still makes sense in light of the CAA prescription drug reporting requirement discussed above.

Additionally, regulators will not begin enforcing the other two machine-readable file requirements until July 1, 2022.

The self-service price comparison tool is scheduled to take effect for plan years beginning on or after January 1, 2023. Enforcement of a substantially similar requirement that was included in the CAA and supposed to take effect for plan years beginning on or after January 1, 2023 has been deferred to plan years beginning on or after January 1, 2023. Additional guidance intended to harmonize the two requirements is expected this year.

Build Back Better Act Hits Roadblock

The $1.8 trillion Build Back Better Act (BBBA), the centerpiece of President Biden's domestic agenda that includes a universal paid leave program is stalled in the Senate and now faces an uncertain future.

Negotiations between the White House and Senator Joe Manchin (D-WV), the lone Democratic holdout in the Senate, broke down in late December when Senator Manchin publicly announced he would not vote for the package. Even though Senate Democrats were trying to move the bill under special rules that allowed them to avoid an expected Republican filibuster, they still needed the support of all 50 Senate Democrats to pass the bill.

As reported in Rewards Policy Insider 2021-22, the House-passed version of the BBBA included a universal paid leave proposal that would have provided up to four weeks of paid family and medical leave each year to almost all workers. Employers would have had the option to provide the benefit directly to employees and qualify for substantial federal subsidies, or to allow their employees to get benefits through the federal program.

Senator Manchin had previously expressed opposition to including paid family and medical leave in the BBBA, and there was speculation that paid family and medical leave would have been omitted from whatever version of the BBBA the Senate ultimately voted on. Now the outlook for the Senate voting on any version of the BBBA, with or without a paid leave provision, is very much uncertain.

That being said, Senate Democrats technically have until September 30, 2022 to pass the BBBA and send it to President Biden for his signature. A lot can happen over the next nine months, so stay tuned.

Special HDHP Exception for Telehealth Services Expires

A special rule that permitted high-deductible health plans to provide below-the-deductible coverage for telehealth and other remote care services is no longer available for plan years beginning after December 31, 2021. Congress so far has failed to act on proposed legislation to extend the special rule.

Background

In order to be eligible to fund a health savings account (HSA), an individual generally must be covered by a high-deductible health plan (HDHP) and also may not be covered by any non-HDHP (i.e., "disqualifying coverage"). With

limited exceptions, HDHPs generally may not provide coverage below the minimum required deductible.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 established a temporary safe harbor for HDHPs to provide below-the-deductible coverage for telehealth and other remote care services. Additionally, the temporary safe harbor provides that coverage for telehealth and other remote care services is not "disqualifying coverage." The temporary safe harbor applies to services provided on or after January 1, 2020, with respect to plan years beginning on or before December 31, 2021.

Several bipartisan bills have been introduced to extend the temporary safe harbor. However, Congress did not act on any of them before the end of the year, and the outlook for action in early 2022 is uncertain.

What Does it Mean for Employers?

Employers that offer HDHPs should make sure their Summary Plan Descriptions and other plan documents are updated to clarify that telehealth and other remote care services will not be covered below the deductible for plan years beginning after December 31, 2021. Additionally, they should update participant communications to explain that coverage for telehealth and other remote care services may now be "disqualifying coverage."

If Congress later acts to reinstate the safe harbor, employers will need to adjust accordingly.

Read future issues of Rewards Policy Insider for any relevant updates.

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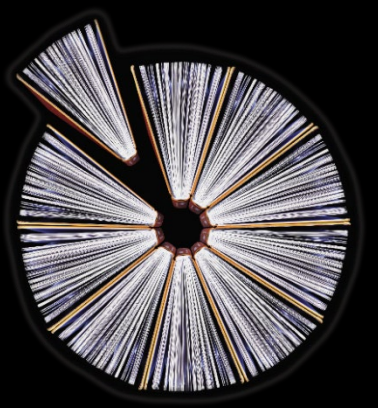

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