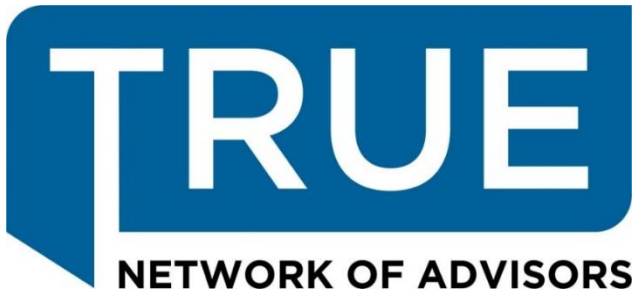
What's New with Group Health Plan Disclosures?



Presented By
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Agenda

- ERISA & GHP Notices & Disclosures 101
- New Disclosure Requirements
  - Transparency in Coverage Regulations
  - CAA 2021 Requirements
  - No Surprises Act
  - MHPAEA Comparative Analyses

ERISA Notices and Disclosures

- Plan Document
  - Must be furnished within 30 days of receiving written request
  - Failure to furnish within 30 days may result in penalties of up to $110 per day
    - Requirement to furnish also applies to other documents, including SPD, latest Annual Report (*i.e.*, Form 5500), trust agreement, any contract or other instruments under which the plan is established or operated

ERISA Notices and Disclosures

- **Summary Plan Description (SPD)**
  - **Must be furnished to each participant within 90 days of becoming covered by the plan**
  - **For new ERISA plans, must be distributed to all participants within 120 days after becoming subject to ERISA**
  - **Updated SPD must be furnished every 5 years if changes made to SPD information or the plan is amended; otherwise, must be furnished every 10 years**

ERISA Notices and Disclosures

- Plan Amendments – SPD or SMM?
  - Administrator of a plan must provide timely notice of amendments that would be *material* to reasonable participants
  - Notice can be in the form of new SPD or SMM
- Summary of Material Modifications (SMM)
  - Alternative to distributing new SPD when amendments are made
  - Must be distributed to all participants not later than 210 days after the end of the plan year in which the change is adopted
  - SMM for **Material Reduction** in group health plan benefits or services
    - Must provide no later than **60 days <u>after</u>** change becomes effective

Group Health Plan Notices & Disclosures

- Summary of Benefits and Coverage (SBC)
  - Who must provide the SBC?
    - Self-insured plan → plan administrator
    - Fully insured plan → insurer and plan administrator share obligation
  - Must provide to participants with enrollment materials and upon renewal/reissuance of coverage; must also provide to special enrollees no later than 90 days following enrollment
  - If re-enrollment is automatic, must provide no later than 30 days prior to the first day of the new plan year
- Notice of Material Modifications
  - Any change affecting the information in the SBC
  - Must provide no later than **60 days prior** to effective date

Group Health Plan Notices & Disclosures

- Notice of HIPAA Special Enrollment Rights
  - HIPAA special enrollment period generally must be made available:
    - If an employee or dependent loses eligibility for group health plan or health insurance coverage;
    - On occurrence of certain life events (e.g., when a person becomes a dependent of an eligible employee because of birth, marriage, adoption, or placement for adoption); and
    - Following an individual's eligibility for a state premium assistance subsidy (e.g., Medicaid or CHIP).
  - Initial notices must be provided at or before the time an employee is first offered the opportunity to enroll in the group health plan.

Group Health Plan Notices & Disclosures

- COBRA Notices
- Newborns' Act Description of Rights
- Women's Health and Cancer Rights Act (WHCRA) Notices
- Wellness Program Disclosures
- Grandfathered Health Plan Notice

Extra Credit

- Employer CHIPRA Notice
- Notice Regarding Availability of Health Insurance Marketplace
  - Within 14 days of an employee's start date
  - No penalty; strategy considerations
- ACA Reporting and Employee Statements (Forms 1095-C) for ALEs

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ERISA Reporting & Related Disclosures

- Form 5500 – Annual Report
  - Due the last day of the 7th month following the end of the plan year (July 31 of the following year for calendar year plans)
  - Up to 2½ month *automatic* extension available with Form 5558
- Summary Annual Report (SAR)
  - Summarizes the data in the 5500
  - Must be distributed to all participants by the later of (i) 9 months after the end of the plan year, or (ii) 2 months after the due date for filing the 5500 (including approved extensions)
- Are you required to file a Form 5500 for your welfare plan(s)?
  - Depends on **PLAN SIZE** and **FUNDING METHOD**
    - **Yes:** Large Plans
    - **Yes:** Funded Plans
    - **No:** Small AND fully-insured, unfunded, or combination fully-insured & unfunded

Are you required to file a Form 5500 for your welfare plan(s)?

Must File if **EITHER** of these is true		
Plan Size		Funding Method
Large Plan – 100+ participants on first day of plan year	AND /OR	Funded Plans – essentially meaning benefits are NOT paid from general assets (e.g., paid from a trust)

Exempt from Filing **ONLY IF BOTH** are true		
Plan Size		Funding Method
Small Plan – Fewer than 100 participants on first day of plan year	AND	Unfunded Plan - essentially meaning benefits are paid from general assets
		Fully-Insured Plan
		Combination Fully-Insured/Unfunded

Transparency in Coverage Requirements

- Applies to non-grandfathered group health plans, but not to account-based plans, excepted benefits, short-term limited-duration insurance, or retiree-only plans.
- Fully insured plans may satisfy the disclosure requirements (and no longer be liable) if the plan requires the issuer to comply by written agreement.
- Self-funded plans may contract with TPAs to provide the information, and include indemnification provisions in such contracts, but will remain liable if the TPA fails to comply.

Transparency in Coverage Requirements

- **Disclosures to participants and beneficiaries:**
  - **Must provide cost-sharing information to participants and beneficiaries upon request.**
  - **Must also provide a disclosure notice that includes various information. A model notice is available on the DOL's website.**
  - **Must be made available through an internet-based, self-service tool that includes certain search capabilities, and must be made available in paper form, if requested by the participant.**
  - **Applies for plan years beginning on or after January 1, 2023 for 500 items and services. Will apply for all items and services for plan years beginning on or after January 1, 2024.**

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Transparency in Coverage Requirements

- **Public disclosures:**
  - Plans must make public the following information online using three machine-readable files:
    - In-network rates;
    - Out-of-network allowed amounts; and
    - Prescription drug negotiated rates.
  - The following must be included in each file:
    - Name and health insurance oversight system (HIOS) identifier (or, if unavailable, the EIN) for each coverage option offered by the plan;
    - Billing code and plain language description for each covered item/service; and
    - Identifiers for in-network and out-of-network providers.
  - Applies for plan years beginning on or after January 1, 2022.

CAA: No Surprises Act

- Effective for plan years beginning on or after January 1, 2022.
- Applies to all group health plans, including grandfathered, except does not apply to excepted benefits, short-term limited-duration insurance, or retiree-only plans.
- Plans must cover emergency care services (i) without requiring preauthorization and (ii) at in-network cost-sharing rates, even if the provider or facility is out-of-network.
  - Similarly, plans covering air ambulance services must cover a participant's out-of-network air ambulance service at in-network cost-sharing rates.
- Providers and facilities are banned from balance billing without consent.

CAA: No Surprises Act

- Plans must pay out-of-network providers, or provide notice of denial of payment, within 30 days of receiving a bill.

- <u>Open Negotiation Period</u>:
  - For services furnished by out-of-network providers (where no state law determines the payment rate), following the providers' receipt of the initial payment or denial, 30-day open negotiation period is required.

- <u>Independent Dispute Resolution</u>:
  - "Independent dispute resolution" process (i.e., binding arbitration) must follow for plans and out-of-network providers who cannot agree upon a rate during the open negotiation period.

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CAA: No Surprises Act

- Plans must make publicly available, post on a public website of the plan, and include on each explanation of benefits (EOB) for an item or service with respect to which the surprise billing protections apply the following:
  - The restrictions on balance billing in certain circumstances;
  - Any applicable state law protections against balance billing;
  - The requirements under the new surprise billing rules; and
  - Information on contacting appropriate state and federal agencies.
- A model notice is available on the DOL's website.

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CAA: Health Transparency Rules and Reporting Requirements

All of the following requirements are effective for plan years beginning on or after January 1, 2022 (unless indicated otherwise).

- **Advanced ID card requirement**
- **Advanced explanation of benefits (EOB)**
- **Notice of continuity of care**
- **Price comparison tool**
- **Updated provider directories**
- **No "gag" clauses allowed on price or quality of care information**
- **Reporting on pharmacy benefits and drug costs**
  - Group health plans must annually report on plan medical costs, prescription drug spending, premiums, and manufacturer rebates received by the plan (first reporting currently due 12/27/21; subsequent reporting by June 1 of each year)

Mental Health Parity Comparative Analysis

- Effective February 10, 2021.
- Applicable to any group health plan that offers mental health or substance use disorder (MH/SUD) benefits.
- If group health plan imposes non-quantitative treatment limitations (NQTLs) on MH/SUD benefits, the plan must perform and document a comparative analysis of NQTLs on MH/SUD benefits vs. medical/surgical benefits.
- Analyses must be available to agencies upon request, and agencies must request at least 20 per year.
- DOL guidance:
  - FAQs
  - Self-Compliance Tool
  - DOL's Webpage on MH/SUD Parity, which includes links to the regulations and additional guidance

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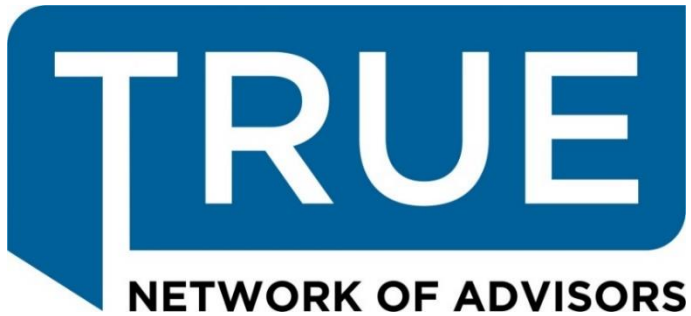

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