NCCMP 2021 Lawyers and Administrators Meeting

April 7, 2021/Kathryn Bakich

Segal

Agenda

American Rescue Plan Act of 2021: COBRA Subsidy

No Surprises Act and Transparency Rule

American Rescue Plan Act of 2021 (ARPA)

Temporary 100% COBRA Subsidy

- Enacted March 11, 2021 as part of the American Rescue Plan Act of 2021, Public Law 117-2
- Federal government will fully subsidize COBRA premiums for 6 months, from April 1, 2021 through September 30, 2021
- Applies when COBRA qualifying event is termination of employment or reduction in hours, except for an individual's voluntary termination
- Subsidy ends earlier than September 30 if individual becomes eligible for other group coverage or Medicare, or reaches end of 18-month COBRA period

COBRA Subsidy

Plan Requirements

- New notice requirements using government models (subsidy availability, subsidy expiration)
- Extended election opportunity for assistance eligible individuals without COBRA election in effect of as April 1, 2021
- Plan/plan sponsor receives subsidy through payroll tax credit – likely will use Form 941 (refundable and advanceable)

COBRA Subsidy: Key Dates

- April 10: Deadline for DOL to release model notices/forms about availability of subsidy and extended election period
- April 25: Deadline for DOL to release model notice about expiration of subsidy
- May 31: Deadline for plan administrators to send out notices/forms about availability of subsidy and extended election period
- Plans must refund COBRA premiums paid for April, etc. within 60 days of when premium was paid to the plan

ARRA Guidance

- The American Recovery and Reinvestment Act (ARRA) established a COBRA subsidy for workers who involuntarily lost their jobs between Sept. 1, 2008, and March 31, 2010. This subsidy was extended through May 31, 2010.
- ARRA guidance is available online at https://www.irs.gov/newsroom/cobra-health-insurance-continuation-premium-subsidy
- Includes Notice 2009-27
- ARPA and ARRA language are similar

Common Questions about COBRA Subsidy

- Must reduction in hours also be involuntary? No
- Is the subsidy available if the termination was for cause? Yes, unless termination was due to gross misconduct
- Is the employee's death an involuntary termination? No
- Are people who elected COBRA last year but dropped it eligible for the subsidy? Yes, if due to reduction in hours or involuntary termination
- Does a second COBRA qualifying event (e.g., death, divorce, aging out) extend the period of time the subsidy could be paid? No

Common Questions about COBRA Subsidy

- Does subsidy apply to plans providing only dental and/or vision? Yes
- Is the subsidy available if COBRA is based on death, disability, or divorce? No
- Does involuntary termination have to be COVID-related? No
- If a participant is eligible for other group health plan coverage or Medicare can they receive the subsidy? No
- Do people get a new COBRA election even if they declined COBRA previously? Yes
- Who gets the payroll tax credit, the contributing employer or the multiemployer plan? The multiemployer plan

No Surprises Act and Transparency Rule

No Surprises Act

- Enacted December 27, 2020 as part of the Consolidated Appropriations Act, 2021, Public Law 116-260
- Applies to most group health plans and insurers, including grandfathered plans
- Retiree-only plans, excepted benefits appear to be exempt

New Rules for Emergency Services

- Participants are now protected from balance billing by out-of-network (OON) providers and are only responsible for in-network cost-sharing for:
  - Non-network emergency services;
  - Non-network providers at in-network facilities
  - Non-network air ambulance services
- Generally effective for plan years beginning on or after January 1, 2022
- ACA's Emergency Room payment rules are repealed

Paying for Out-of-Network Claims

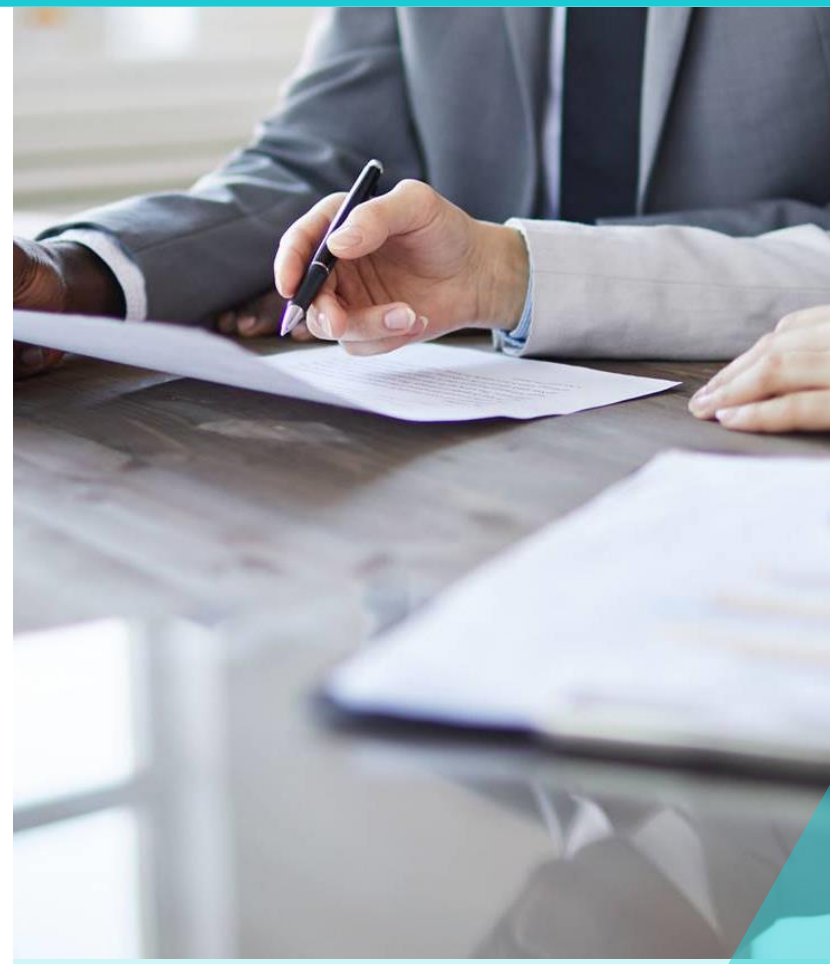
- Plans sets participant cost sharing based on a “recognized amount”, which will be based on median in-network contracted rates
  - Participant only responsible for in-network cost-sharing (copays, deductibles, coinsurance)
  - Cost-sharing must count toward in-network deductible and out-of-pocket maximum
- Plan must pay the non-participating health care provider or facility within 30 days of receipt of bill
  - Plan must send either a denial or initial payment
  - There is a 30 day open negotiation period for providers and plans to reach agreement on claims

Independent Dispute Resolution

- The amount the health plan has to pay the OON provider is determined through an independent dispute resolution (IDR) process
  - There is no threshold amount for claims to go to the IDR process
  - The process is "baseball style", meaning that the IDR reviewer picks one of the parties' offers
  - Losing party pays IDR costs

Independent Dispute Resolution

- The IDR reviewer is to consider certain factors in making its decision, including the median in network rate for the service, as well as other information the parties provide
- The IDR reviewer cannot consider UCR, billed charges, or Medicare/Medicaid rates in making its decision



Transparency Final Rule

Effective for plan years beginning on or after January 1, 2022

Plan must post on the internet machine-readable files updated monthly that include:

- An in-network rate machine-readable file
  - If underlying fee schedule rates used to calculate cost-sharing, those much be disclosed
- An out-of-network allowed amount machine-readable file
- A prescription drug machine-readable file

Transparency Final Rule

- Effective for plan years beginning on or after January 1, 2023, with respect to 500 items and services listed in rule
- Effective for plan years beginning on or after January 1, 2024 for all covered items and services

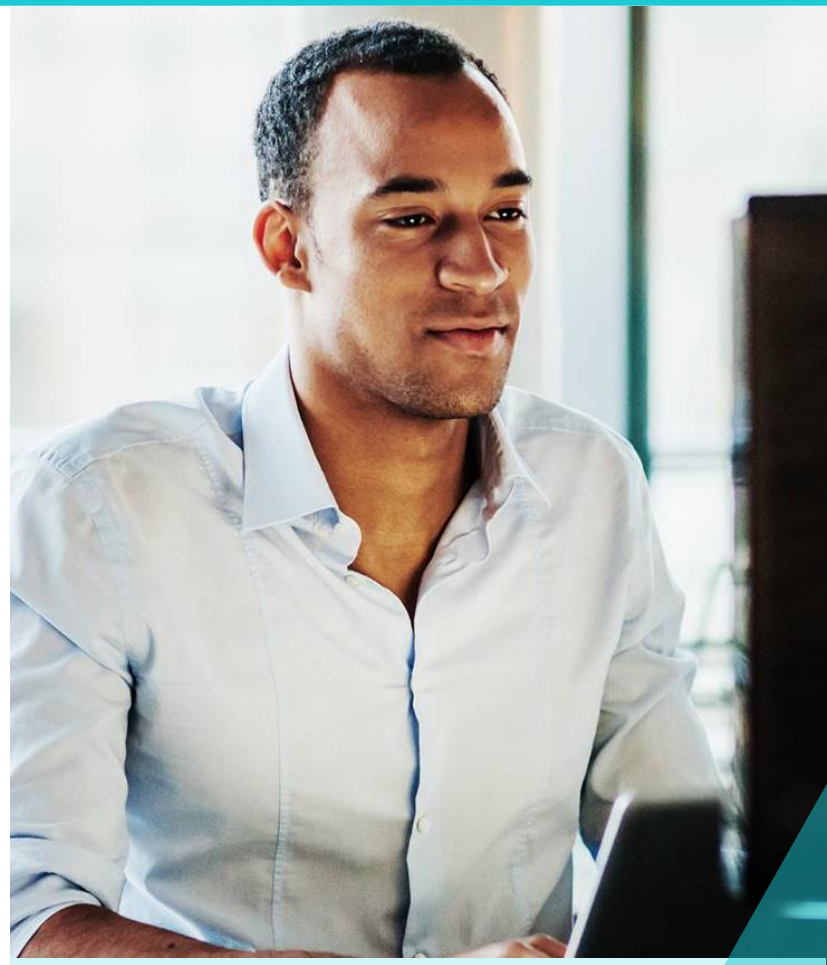
Internet-based self-service tool

- Real time tool a participant can use to search for cost-sharing information that is accurate at the time of request

Internet Based Self-Service Tool

Price look-up tool requirements must allow the user to search for:

- Cost-sharing information for a covered item or service by a specific provider or all in-network providers; and
- An out-of-network allowed amount, percentage of billed charge, or other rate for a covered item to service provided out-of-network providers



Price Tool Elements

1	Estimated Cost-Sharing (deductibles, copayments, coinsurance)
2	Accumulated amounts
3	In-Network negotiated rates
4	Out-of-Network allowed amounts
5	Items and services in bundled arrangements, if applicable
6	Any coverage prerequisites, e.g., preauthorization, concurrent review, step therapy, fail first protocols, etc.
7	Disclosure Notice (model available)

Transparency Final Rule

Insured group health plans may require insurer to comply

Self-insured group health plans may enter into written agreement for compliance with service provider, but plan retains compliance responsibility

Transparency Final Rule

Good faith rule

Plans that act in good faith and with reasonable diligence are not out of compliance if:

- An error or omission is made in a disclosure, provided it is corrected as soon as practicable
- Its internet website is temporarily inaccessible, provided the information is available as soon as practicable
- If plan needs to obtain information from another entity to comply, will not be out of compliance unless plan knows or reasonably should have known that the information is incomplete or inaccurate

Enforcement and Penalties

- Same enforcement framework as ACA market reforms
- Self-funded plan failure to comply would subject the plan to monetary penalties under IRC Section 4980D
- $100 day per violation per affected participant

Surprise Billing Law compliments Transparency Rule

- Health care providers must send plan and an estimate of charges, and plan must then send an Advance Explanation of Benefits
- Health plans must offer participants a price comparison tool both online and via telephone
- Contracts must prohibit gag clauses

And more . . .

- ID Cards must include additional information (deductibles, OOP maximum)
- Plans must maintain provider directories
- Patients entitled to continue care during network contract transitions
- Prescription drug claim reporting to federal government

Compliance Plan

ct and Final Transparency Rule

s and is based upon guidance available as of February 16, 2021. Additional guidance is
ctive dates, which may impact the contents of this document. Plan sponsors should
ability of these laws to their plan and its operations.

	Responsible Party	Effective Date	Plan Actions
th plan			
implementation period			
thered plans. However, er the Affordable Care sions to determine		Plan years beginning on or after January 1, 2022	

1. If non-grandfathered, amend plan to eliminate ACA emergency room payment rules
2. Amend plan rules to cover emergency services without prior authorization
3. Amend plan rules to apply cost sharing in the same manner at participating and non-participating providers and facilities, both subject to and accumulating to the in-network deductible and out-of-pocket maximum.
4. Define:
   - Emergency medical condition using the prudent layperson standard
   - Emergency department of a hospital to include an independent freestanding emergency department.
   - Emergency services
5. Amend plan to set forth standards for payment to a non-network provider or facility
6. Modify External Review procedures to include determinations regarding emergency services and air ambulances

Segal 1

For More Information

www.segalco.com/consulting-insights/transparency-laws

Questions?