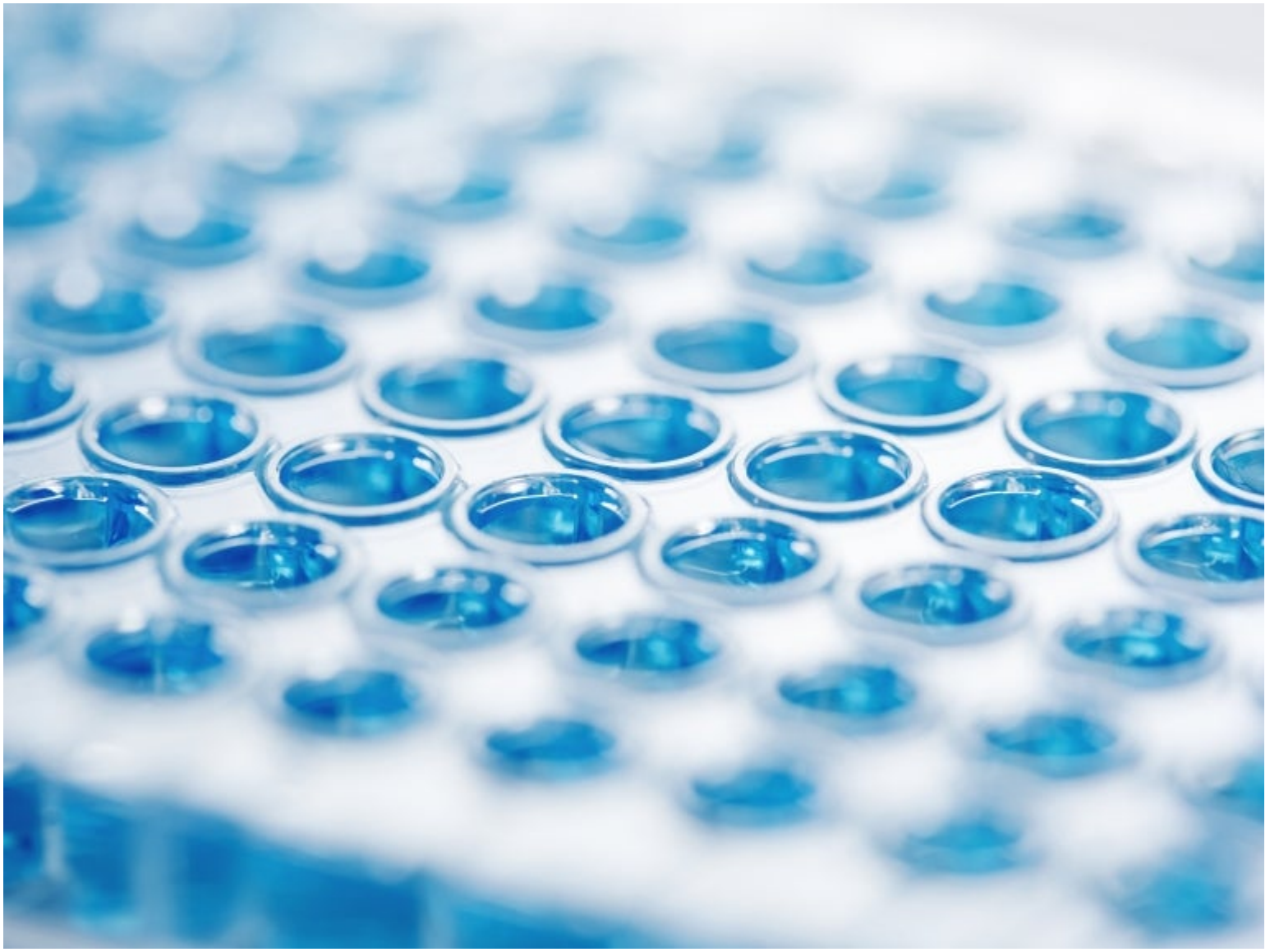

There are many new and expanding legal requirements for group health plans and issuers of group health plan coverage to pay attention to this year. Many of these requirements were enacted as part of the Consolidated Appropriations Act of 2021, which passed in December 2020. This update describes the key legal requirements that we are seeing the most questions or movement on from clients. This is not an exhaustive list, and we encourage plan sponsors to reach out to their advisors, carriers, and other vendors supporting plan administration and design that could be affected by these new requirements.

Mental Health Parity Comparative Analysis

Group health plans (and issuers) providing mental health and/or substance use disorder benefits must have a comparative analysis conducted of benefit design and the application of nonquantitative treatment limitations (NQTLs). NQTLs differ from financial limitations like cost-sharing and quantitative limitations like visit limits. NQTLs include limitations such as medical management standards for medical necessity or appropriateness, experimental or investigative exclusions, and drug formulary designs. *See* 29 CFR 2590.712(c)(4). Accordingly, while plan design and coverage terms are relevant, a self-funded plan sponsor will need to coordinate with its third-party claims administrator to complete this analysis (and perhaps others—e.g., if medical necessity determinations are outsourced to another vendor).

Coverage of COVID-19 OTC Tests

As of January 15, 2022, group health plans (and issuers) must provide 100% coverage of over-the-counter COVID-19 diagnostic tests, without cost-sharing or medical management limitations—even if the test was purchased without a provider prescription or clinical assessment. However, the plan may place dollar or quantity limits in certain circumstances, and the plan may also implement protections against fraud and abuse. Read more about this on our sister blog, Coronavirus (COVID-19): Guidance for Businesses.

Medical Surprise Billing Protections, Including Independent Dispute Resolution Process

For plan years beginning on or after January 1, 2022, group health plans (and issuers) must implement protections against balance billing and out-of-network cost-sharing with respect to emergency services, as well as certain non-emergency and air ambulance services. Plans and issuers must also implement additional protections, including patient and provider dispute resolution processes and expanded rights to external review.

Plans and issuers must also provide notice about these surprise billing protections, which must be made publicly available, posted on a public website, and included in explanations of benefits. The U.S. Department of Labor (DOL) issued a model notice.

Self-funded plan sponsors should also confirm whether to opt in to any state-level protections. Most states have insurance consumer protections, but a subset of states (e.g., Washington state) have enacted their own surprise billing requirements.

Continuity of Care and Transitional Care Protections

For plan years beginning on or after January 1, 2022, group health plans (and issuers, providers, and facilities) must provide notice to "continuing care patients" when expirations, nonrenewals, or terminations of certain contractual relationships may result in changes in provider or facility network status, and thus affect coverage of

benefits. Such individuals must also be given an opportunity to request transitional care, which would permit them to elect to continue to access such benefits for up to 90 days. Per joint agency FAQs, while awaiting additional rulemaking, plans should implement the continuity of care requirements using a good faith and reasonable interpretation of the statute (Code Section 9818 and ERISA Section 718).

Provider Directories and Cost-sharing Protections

As another protection against surprise billing (refer to the joint agency FAQs), for plan years beginning on or after January 1, 2022, group health plans (and issuers) must establish a process to update and verify the accuracy of provider directory information and establish a protocol for responding to requests from a participant, beneficiary, or enrollee about a provider's network status. Also, databases must be maintained to ensure accuracy of provider directories. If services are received in reliance on incorrect information (e.g., provider listed as in network was out of network), then the plan must provide cost-sharing relief.

Brokerage and Consulting Compensation Disclosures

For contracts entered into, extended, or renewed on or after December 27, 2021, group health plan fiduciaries must obtain disclosures from vendors expected to receive at least $1,000 to provide brokerage services or consulting, to support fiduciary obligations to pay only reasonable compensation for such services. The statute lists types of brokerage and consulting services requiring disclosure. However, per the DOL Field Assistance Bulletin 2021-03, these terms are to be construed broadly—this is not necessarily limited to the "broker of record" and the vendor need not have a broker license. Pending further guidance, plan fiduciaries and vendors must comply based on a good faith and reasonable interpretation of the statute (ERISA Section 408(b)(2)), which could include analogizing to requirements and processes in place for similar disclosures required for qualified retirement plans.

Prescription Drug Benefits and Cost Reporting

Beginning December 27, 2022, and annually thereafter, group health plans (and issuers) must submit information about prescription drug benefits and spending—including information about frequently dispensed drugs, costliest drugs, and rebates paid by drug manufacturers to plans, third-party administrators, and pharmacy benefit managers. While it is expected that the carrier, third-party claims administrator, or pharmacy benefit manager will handle reporting on behalf of a self-funded plan, plan sponsors should specifically confirm that is the case. Enforcement has been delayed via commentary to joint agency interim final regulations, with the first deadline extended to December 27, 2022, for submissions on 2020 and 2021 data. Thereafter, reporting is due annually by June 1.

* * *

The developments summarized above are only a few of the many changes that could affect employer-sponsored health plan coverage in 2022. Employers and other health plan sponsors with questions about these new group health plan requirements should consult experienced counsel.

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