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INFORMATION MEMO
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# Year-End Appropriations Act Contains a Number of Important Provisions Impacting Group Health Plans

Former President Trump signed the Consolidated Appropriations Act, 2021 (the Act) into law on Dec. 27, 2020. The Act contains multiple provisions impacting employee benefits. Our information memo summarized the COVID-19 and other disaster-related employee benefits provisions contained in the Act.

Here is an overview of some of the more important employee benefits provisions in the Act impacting group health plans, including: (1) new rules regarding surprise medical billing; (2) new patient choice provisions; (3) a new fee dispute resolution process; (4) new rules providing transparency in health care; (5) new continuity of care rules; (6) new rules regarding parity in mental health and substance use disorder benefits; and (7) new reporting requirements regarding pharmacy benefits and drug costs.

These provisions generally become effective for plan years beginning on or after Jan. 1, 2022, unless otherwise noted below.

While these provisions generally apply to group health plans and health insurance issuers, some of the provisions discussed below apply to healthcare providers and facilities. It is important to note that the provisions applicable to group health plans and insurance issuers apply to both self-funded and insured plans. Sponsors of self-funded plans should discuss these provisions with their third-party administrators and/or other service providers to ensure they will be properly addressed.

## I. Surprise Medical Billing

The Act provides for various new rules regarding surprise medical billing, which commonly fall into the following three categories: (1) surprise medical billing rules for emergency services; (2) surprise medical billing rules for non-emergency services performed by nonparticipating providers at participating facilities; and (3) surprise medical billing rules for air ambulance services.

In general, the surprise medical billing rules for each category require that if a group health plan or health insurance issuer covers such service (if provided by a participating provider or facility, as the case may be), then it must also cover such service if provided by a non-participating provider or facility, as the case may be, without imposing a greater cost-sharing requirement on the individual, and apply any such cost-sharing amount paid to that individual's in-network deductible or out-of-pocket maximum. The surprise medical billing rules for each category also provide for certain payment timing rules.

Furthermore, the claims procedure external review rules applicable to group health plans and insurance issuers must be extended to the surprise medical billing provisions as well.

## II. Patient Choice Provisions

A. *Choice of Primary Care and Pediatric Care Professional*

If a group health plan or health insurance issuer requires or provides for the designation of a participating primary

or pediatric care provider, then the plan or issuer must permit each participant, beneficiary and enrollee to designate any such participating primary provider who is available to accept such individual.

B. *Access to Obstetrical and Gynecological Care*

A group health plan or health insurance issuer may not require authorization or referral in the case of a female participant, beneficiary or enrollee who seeks coverage for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

## III. Fee Dispute Resolution Process

A. *Process to Determine Out-of-Network Rates to be Paid by Health Plans*

With respect to items or services furnished by a non-participating provider or facility for which a payment is required to be made by the group health plan or health insurance issuer, there will be a 30-day period for the parties to openly negotiate an agreed upon amount for payment. If no resolution is reached during the 30-day open negotiation period, then, within four days of the end of such period, either party may initiate the independent dispute resolution (IDR) process by notifying the other party and the U.S. Department of Health and Human Services (HHS). In this event, a certified IDR entity will determine the amount of payment. HHS, the U.S. Department of Labor (DOL) and the U.S. Department of Treasury (Treasury) will issue rules regarding this process.

B. *Patient and Provider Dispute Resolution*

The Secretary of HHS will establish a process for uninsured individuals and health care providers or facilities to resolve disputes regarding the amount uninsured individuals are required to pay for services rendered by such providers and facilities. This dispute resolution process will only apply to uninsured individuals who received a good faith estimate of expected charges from the provider or facility, and then such individual is billed an amount that is substantially in excess of such estimate.

## IV. New Rules Providing Transparency in Health Care

A. *In-Network and Out-of-Network Deductibles and Limitations*

Any plan or insurance identification card issued by a group health plan or health insurance issuer must include information, in clear writing, regarding any deductible or out-of-pocket maximum limitation. Furthermore, such identification card must also include a telephone number and website address to obtain consumer assistance information.

B. *Advance Cost-Estimates*

Group health plans and health insurance issuers must provide participants or enrollees who are scheduled to receive services with notices containing information, within specified time frames, regarding contracted rates for the service and good faith estimates.

C. *Information Provided Upon Request and for Scheduled Appointments*

Health care providers and facilities must ask whether an individual scheduling an item or service is enrolled in a group health plan or insurance coverage and provide a notification in clear and understandable language of the good faith estimate of expected charges. This notice must also be provided within certain time frames.

D. *Maintenance of Price Comparison Tool*

Group health plans and health insurance issuers must offer price comparison guidance by phone and make a price comparison tool available on the plan or insurance issuer's website, showing the amount of cost-sharing that a participant or enrollee would be responsible for paying with respect to an item or service.

E. *Provider Directory Information*

A group health plan or health insurance issuer must establish a database on its website that lists each provider and facility that has a contractual relationship with the plan or insurance issuer, and directory information for each provider or facility. This information will need to be verified at least every 90 days, and participants and enrollees that rely on provided information that is inaccurate may be able to receive cost-sharing relief. Furthermore, providers and facilities must establish processes to ensure the timely provision of directory information to the plan or insurance issuer and may also be responsible for providing cost-sharing relief to individuals who rely on inaccurately provided information.

F. *Protections from Balance Billing*

A group health plan or health insurance issuer must make publicly available, post on its website and include in each explanation of benefits information (in plain language) regarding the requirements and prohibitions on balance billing in certain circumstances, including information that may be required by state law. These notices must also include information for contacting the appropriate federal or state agencies in the case an individual believes such balance billing protections have been violated.

G. *Prohibitions on Gag Clauses for Price and Quality Information*

Group health plans and insurance issuers may not enter into agreements with providers (or other similar entities) that directly or indirectly restrict the plan or issuer from providing provider-specific cost or quality of care information, electronically accessing de-identified claims (consistent with privacy protections) or sharing such information or data with a business associate (consistent with privacy protections). Plans and issuers will have to attest to their compliance with this requirement to HHS. This provision became effective on Dec. 27, 2020 (i.e., the Act's enactment date).

## V. Continuity of Care

Various new requirements are imposed on group health plans and insurance issuers when the contractual relationship between an individual's provider or facility and the plan or coverage is terminated. One requirement is that individuals in this scenario may elect continued transition care from the provider or facility under the same terms and conditions for a specified period of time. In these instances, the providers or facilities must accept payment and continue to adhere to the plan or issuer's policies for the applicable period of time.

## VI. Parity in Mental Health and Substance Use Disorder Benefits

If a group health plan or insurance issuer provides both medical and surgical benefits and mental health or substance use disorder benefits that impose nonquantitative treatment limitations (NQTLs) on the mental health or substance use disorder benefits, then the plan or issuer must perform and document comparative analyses of the design and application of the NQTLs, and upon request, make the same available to federal and state authorities. This provision became effective on Feb. 10, 2021.

### VII. Reporting Pharmacy Benefits and Drug Costs

No later than Dec. 27, 2021, and on June 1 of each year thereafter, group health plans and health insurance issuers must submit to HHS, the DOL and Treasury various information regarding pharmacy and drug costs, such as, for example, the 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan or coverage and the total number of paid claims for each drug.

We anticipate more guidance will be issued by the applicable agencies in the near future regarding the new provisions addressed above.

If you have any questions about this information memo, please contact Daniel J. Nugent, any attorney in our Employee Benefits and Executive Compensation practice or the attorney at the firm with whom you are regularly in contact.

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