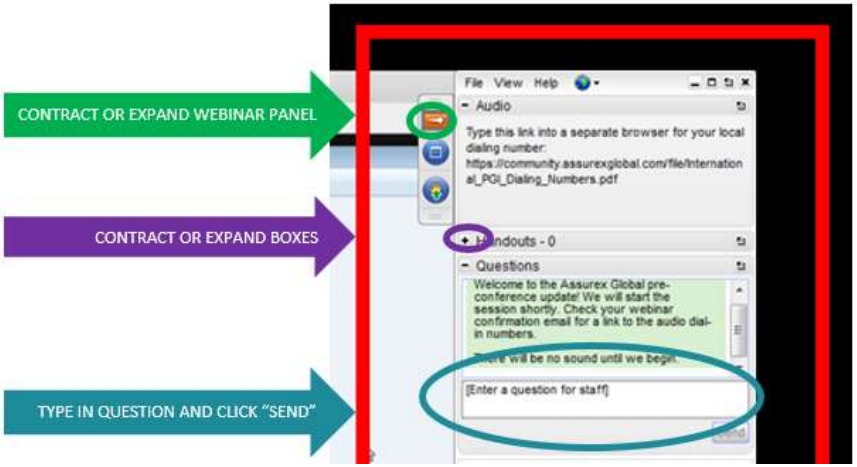
2021

Health Cost Transparency, Surprise Billing, and Vaccine Incentives

Presented by Benefit Comply

Dependent Care Assistance Plans

- Welcome! We will begin at 3 p.m. Eastern
- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.
- You will be able to submit questions during the webinar by using the “Questions” or “Chat” box located on your webinar control panel.
- Slides can be printed from the webinar control panel – expand the “Handouts” section and click the file to download.



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Agenda

- Regulatory Update
  - End of COBRA Subsidy
- Health Cost Transparency
- Surprise Billing
- Vaccination Mandates and Incentives

Regulatory Update

Regulatory Update

- COBRA Subsidy Ends September 30, 2021
  - Don’t forget to send the “End of Subsidy Notice” to individuals receiving the subsidy
  - Individuals will be eligible for a Special Enrollment Period (SEP) to purchase individual coverage through a public exchange when subsidy ends
  - Individuals can continue COBRA for the remainder of their maximum coverage period by paying applicable COBRA premiums beginning in October
- IRS §4980H Collection Efforts
  - Have started enforcing 2019 reporting
    - We first see letter 5699 - comparing how many W-2s were filed and IRS thought they should have reported
    - Then the other enforcement letters including the 226J
- IRS Released an FAQ Contraception Coverage Exception
  - Plan to revisit the rules to determine if changes need to be made

Health Cost Transparency

The Big Picture

- Hospital Cost Transparency Final Rule
  - Based on legislation originally contained in The Affordable Care Act but only partially implemented
  - Published November 2019 – Effective January 2021
- Transparency in Coverage Final Rule (TiC Final Rules)
  - Published November 2020
  - Based on legislation originally contained in The Affordable Care Act but never fully implemented
    - Carriers and Health Plans must publicly release data files with detailed reimbursement rate information
    - Price comparison tool and personalized cost estimates
- Consolidated Appropriations Act (CAA) Transparency Rules & The No Surprises Act
  - Stimulus bill passed by Congress in December 2020
    - Surprise Billing Restrictions
    - Price comparison tool and “Advanced EOB”
    - ID Card changes
    - Provider “good faith estimate” requirement
    - Rx Cost Reporting
- Regulatory FAQ delaying many, but not all, implementation dates released August 20, 2021

Hospital Cost Transparency

Hospital Cost Reporting

- Requirement Basics – Effective 1/1/2021
  - Hospitals must publish a machine-readable file containing these types of charges for all “items and services” provided by the hospital
    - Gross charges - The non-discounted rate, as reflected in a hospital’s chargemaster
    - Discounted cash prices - The rate the hospital would charge individuals who pay cash
    - Payer-specific negotiated charges - The rate that a hospital has negotiated with a third-party payer
    - De-identified minimum negotiated rates - The lowest rates that a hospital has negotiated with all third-party payers without identifying the payer
    - De-identified maximum negotiated rates - The highest rates that a hospital has negotiated with all third-party payers without identifying the payer
  - Hospitals must publish a more consumer friendly list for the hospital’s 300 most “shoppable services,”
    - CMS listed 70 shoppable services that must be included; up to the hospital to select the remaining 230

Rx Cost Reporting

Rx Cost Reporting

- Detailed Rx and other cost data must be reported to regulatory agencies every 6 months
  - Who?
    - Employer Plan Sponsors and Carriers
  - Effective beginning ~~December 27, 2021~~ - Delayed indefinitely until further guidance is issued
  - What Must be Reported
    - Rx spending by plan and participant
    - Total spending by the plan by types of cost (e.g., hospital, primary care, specialty care, provider and clinical service costs, prescription drugs, wellness)
    - Number of enrollees
    - 50 most common brand prescription drugs paid by the plan and the total claims paid for each drug
    - 50 most costly drugs by total annual spending and the annual amount spent for each of the 50 drugs
    - 50 drugs with the greatest year-over-year cost increase and the change in amounts paid by the plan
    - Average monthly premiums paid by the employer and the participants
    - And more...

Provider Good Faith Estimate

Provider Good Faith Estimate

- Requirement Basics
  - Providers must provide patients with a good faith estimate of expected costs
  - Information must be provided to the patient's health plan
  - If patient is not covered by a health plan, the notice must be provided to the individual
- Effective Date
  - ~~January 2022 –~~ Enforcement delayed indefinitely for patients covered by a health plan until further guidance is issued

Health Plan Cost Transparency

Health Plan Cost Transparency and Disclosure

- Pricing Data Disclosure
  - Effective beginning in ~~January 2022~~ July 2022 - Plans and insurers must publicly post three machine-readable files
    - The In-Network Rate File
      - All applicable rates with in-network providers for all covered items and services (including negotiated rates, underlying fee schedules, or derived amounts)
    - The Allowed Amount File
      - one on billed charges and allowed amounts for covered items and services provided by out-of-network providers
    - The Prescription Drug File - Enforcement delayed indefinitely
      - Negotiated rates and historical net prices for prescription drugs furnished by in-network providers
  - This information must be updated monthly and made publicly available on an insurer's or plan's website free of charge

Health Plan Cost Transparency and Disclosure

- Advanced Cost Estimate “Price Comparison Tools”
  - Upon request, plans and insurers must disclose estimates of cost-sharing for covered health care items and services from a particular provider.
    - Disclosure must be by “web tool” and paper when necessary
  - Effective Dates
    - TiC Final Rules - 500 items & services January 2023 - all items and services January 2024
    - CAA – January 2022
    - Enforcement delayed until January 2023

Health Plan Cost Transparency and Disclosure

- CAA Good Faith Estimate “Advanced EOB”
  - Effective ~~January 2022~~ Delayed Indefinitely until future rules are released
  - Upon receiving good faith estimate from a provider of services, plan must provide an advanced explanation of benefits to the individual including the following information:
    - The network status of the provider or facility
    - The contracted rate for the item or service, or if the provider or facility is not a participating provider or facility
    - a description of how the individual can obtain information on providers and facilities that are participating
    - The good faith estimate received from the provider
    - A good faith estimate of the amount the plan or coverage is responsible for paying, and the amount of any cost-sharing for which the individual would be responsible for paying with respect to the good faith estimate received from the provider
    - Disclaimers indicating whether coverage is subject to any medical management techniques

Other Issues

Other Issues

- No Gag Clause in Provider Contracts
  - Effective December 27, 2020
- ID Card Requirements
  - ID cards must include deductible and out-of-pocket maximum amounts
  - Effective for plan years beginning January 1, 2022
- Provider Directory Accuracy
  - If an individual receives services from an out-of-network provider and relied on inaccurate provider directory information, the plan must play the claim as if it was provided in network
  - Effective for plan years beginning January 1, 2022

Surprise Billing

Surprise Billing

- Effective for Plan Years beginning January 1, 2022
- Employer Responsibility
  - Employers typically do not process the claims
    - Fully-insured plans carrier principally responsible for compliance
    - Self-insured plans - The plan sponsor/employer is responsible for compliance
      - TPA contracting and due diligence

Surprise Billing

- Types of Medical Service and Claims Affected
  - Out-of-Network Emergency Services
    - Addresses the “rent an emergency Doc” problem
  - Air Ambulance
  - Out-of-Network Providers in an In-Network Facility (Anesthesiologists, Radiologists, Etc.)
- Payers' payment to OON provider will initially be based on:
  - State all-payer database
  - Other state balance billing laws (self-insured plans can opt-into state laws)
  - “Qualified Payment Amount” (QPT)
    - = Median of the payer’s contracted rates for that particular service
- Balance Billing Protection
  - The member cost share will be calculated as if service was provided in-network and provider is prohibited from balance billing the individual

Surprise Billing

- Payment Dispute Resolution
  - If OON providers refuses payers “offer” it goes to an Independent Dispute Resolution (IDR) process
    - Payer submits $ offer – Provider submits $ offer – Arbiter chooses one!
    - If payer wins provider cannot balance bill the patient
- Notices
  - General Notice
    - Posted on Website
      - Unclear if self-insured employers will be required to do this or it is sufficient for TPA to post
    - Model Notice available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act
    - In all EOBs
  - State “Opt-in Notice”
    - For plans that that opt-in to more restrictive balance billing rules.
  - Other notices that will be responsibility of the payer
    - General notice on EOB, notice of payment details to OON providers

Summary and Review

Summary of Timing

- 2021
  - Hospital Cost Reporting – January 2021
- 2022
  - Health Plan Data Files - Beginning in ~~January 2022~~ July 2022
  - ID card and Provider Directory Accuracy – January 2022
  - Surprise Billing rules and balance billing protection – Plan years starting January 1, 2022
- 2023
  - Price Transparency Tools - TiC Final Rules - 500 items & services January 2023 - all items and services January 2024, ~~CAA – January 2022~~ - Enforcement delayed until January 2023

Summary of Timing

- Enforcement Delayed Until Further Notice
  - RX Cost Reporting ~~eff. beginning Dec. 27, 2021~~ - Delayed Indefinitely until further guidance is issued
  - Provider Good Faith Estimate ~~January 2021 –~~ Enforcement delayed Indefinitely for patients covered by a health plan until further guidance is issued
  - CAA Good Faith Estimate “Advanced EOB” -Effective ~~January 2022~~ Delayed Indefinitely until future rules are released

Thoughts for Employers

- Transparency Rules
  - Employers imply do not have access to provider specific reimbursement data necessary to meet most of the transparency requirements
    - Fully-Insured Plans
      - Carrier is responsible for most aspects of the requirements
    - Self-insured Plan Sponsors
      - Technically still responsible for the plan's compliance
      - Employer responsible for administrator due diligence and contracting
- Rx Reporting Rules
  - Contained significant requirements that would have been the responsibility of the employer
    - Delayed Indefinitely so take a wait and see attitude

Vaccination Mandates and Incentives

The Big Questions

- Can the employer mandate employee vaccinations?
  - Yes – EEOC guidance and numerous courts have confirmed employer right to mandate employee vaccination
    - ADA health/disability related accommodations
    - Title VII religious objection accommodations
- Can an employer exclude unvaccinated employees from the health plan or refuse to pay COVID related medical claims?
  - No - We Don't Think So
    - HIPAA discriminating against an individual based on a health status-related factor
    - Receipt of health care is listed as a health status-related factor
- Can the employer incent employees to be vaccinated?
  - Yes
    - Monetary (e.g. cash, gift cards, etc.) – treat as taxable income
    - Paid time off to be vaccinated
    - Follow Employer Wellness Plan Rules

Employer Wellness Plan Vaccination Incentives

- HIPAA Wellness Rules
  - Obtaining a vaccine considered health-contingent, rather than merely participatory
    - Offer a reasonable alternative standard or waives the requirement for those who cannot participate due to health status and provides notice of the availability of a reasonable alternative standard
    - Limits the incentive to no more than 30% of the cost of health coverage
      - The 30% incentive limit includes all health contingent wellness incentives provided by the employer
- EEOC wellness rules
  - EEOC guidance indicates that if the vaccine is obtained from a third party unrelated to the employer it is not subject to the EEOC rules
    - Flexibility for the employer to provide an incentive (Subject to HIPAA rules)
  - If the employer coordinates an onsite vaccination clinic or directly provides vaccination EEOC wellness rules may apply
    - Limiting incentives to de minimis amount
    - Confidentiality notices
    - Providing reasonable accommodations to those with disability or religious-based objections

NOTE TO EMPLOYER: As your employee, I am requesting that you review this document, provide the requisite information, and sign the form, in regards to your requirement that employees get a Covid-19 emergency use authorization (EUA) investigational vaccine.

6) The FDA's guidance[13] on emergency use authorization of medical products requires the FDA to "ensure that recipients are informed to the extent practicable given the applicable circumstances… **[t]hat they have the option to accept or refuse the EUA product**…." Are you aware of this statement? Have you informed all employees that they have the option to refuse?

7) With respect to the emergency use of an unapproved product, the Federal Food, Drug and Cosmetic Act, Title 21 U.S.C. 360bbb-3(e)(1)(A)(ii)(I-III)[14] reiterates that individuals be informed of "**the option to accept or refuse administration of the product**, [and] of the consequences, if any, of refusing administration of the product, and of the alternatives to the product that are available and of their benefits and risks." If EUA Covid-19 investigational vaccines are ever approved by the FDA, state legislation would be required to allow companies to mandate the Covid-19 injections. Are you aware of these facts?

developed by the manufacturers of the injections (Pfizer/BioNTech, Moderna, Oxford/AstraZeneca, and the Johnson & Johnson subsidiary Janssen). The fact sheets must provide the most current and up-to-date information on the injections, and vaccine recipients must also receive information about adverse events. Have you read, understood, and provided me (and all other employees) with these

foundation of ethical medicine—no one may be coerced to participate in a medical experiment. The individual's consent is absolutely essential. No court has ever upheld a mandate for an EUA vaccine. **In *Doe #1 v. Rumsfeld, 297 F. Supp. 2d 119 (2003)*[15], a federal court held that the U.S. military could not mandate EUA vaccines for soldiers: "…[T]he United States cannot demand that members of the armed forces also serve as guinea pigs for experimental drugs"** (*Id.* at 135). Are you aware of this?

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