PART 5 | Consolidated Appropriations Act, 2021

Advance EOB, Patient/Consumer Protections, and Reporting

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STRATEGIC SERVICES GROUP

On December 27, 2020, former President Trump signed the Consolidated Appropriations Act, 2021 (Appropriations Act). The Appropriations Act amends Title XXVII of the Public Health Service Act (PHSA), Part 7 of Title I of the Employee Retirement Income Security Act of 1974 (ERISA), and Chapter 100 of the Internal Revenue Code of 1986 (IRC). This Advisor summarizes additional requirements that plans should be aware of and will generally be effective for plan years beginning on or after January 1, 2022, unless otherwise noted.

Advance Explanation of Benefits

Under the Appropriations Act, a group health plan or health insurance issuer offering group or individual health coverage that receives a required notice from a provider or health care facility that contains a good faith estimate of the expected charges for furnishing an item or service to a plan participant, beneficiary, or enrollee, must provide an advance Explanation of Benefits (EOB) to the participant, beneficiary, or enrollee no later than one business day after the plan or coverage receives the required notice from the provider or health care facility. However, if the item or service is scheduled at least 10 business days before such item or service is to be furnished, the plan or issuer must provide the advance EOB within three business days of receiving the required notice from the provider or health care facility. Also, if a plan participant, beneficiary, or enrollee requests the advance EOB, the plan or issuer must provide the advance EOB within three business days of receiving the request.

The advance EOB must contain the following information:

- Whether or not the provider or facility is a participating provider or a participating facility under the plan or coverage with respect to the item or service.
    - If the provider or facility is a participating provider or facility under the plan or coverage with respect to the item or service, the advance EOB must include the contracted rate.
    - under the plan or coverage for the item or service based on the billing and diagnostic codes provided by the provider or facility.
    - If the provider or facility is a nonparticipating provider or facility under the plan or coverage, the advance EOB must include a description of how the individual may obtain information on providers and facilities that are participating providers and facilities under the plan, if any.
- The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.
- A good faith estimate of the amount the plan or coverage is responsible for paying for items and services included in the estimate.
- A good faith estimate of the amount of any cost sharing for which the participant, beneficiary, or enrollee would be responsible for the item or service (as of the date the advance EOB is being provided).
- A good faith estimate of the amount that the participant, beneficiary, or enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan or coverage (as of the date the advance EOB is being provided).

- If the item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-protocols) for coverage under the plan or coverage, the advance EOB must include a disclaimer that coverage for such item or service is subject to such medical management technique.
- A disclaimer that the information provided in the advance EOB is only an estimate based on the items and services reasonably expected, at the time of scheduling (or requesting) the item or service, to be furnished and is subject to change.
- Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required as noted above.

Choice of Health Care Professional and Access to Care

Choice of Health Care Professional

Under the Appropriations Act, a group health plan that requires or provides for designation by a participant or beneficiary of a participating primary care provider must allow each participant and beneficiary to designate any participating primary care provider who is available to accept such individual.

Access to Pediatric Care

In the case of a person who has a child who is a participant or beneficiary under a group health plan and the plan requires or provides for the designation of a participating primary care provider for the child, the plan must allow the person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan.

Access to Obstetrical and Gynecological Care

A group health plan that provides coverage for obstetric or gynecological care and requires the participants or beneficiaries to designate their primary care provider under the plan may not require authorization or referral by the plan, issuer, or any person (including a designated primary care provider) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

Consumer Protections Through Application of Health Plan External Review in Cases of Certain Surprise Medical Bills

The Appropriations Act instructs the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (Treasury) to require group health plans and health insurance issuers offering group or individual health insurance coverage to apply the federal external review process, under paragraph (1) of Section 2719(b) of the Public Health Services Act with respect to any adverse determination by the plan or issuer regarding surprise medical bills, including air ambulance bills, as defined in the No Surprises Act, including whether the item or service is protected from balance billing under the No Surprises Act.

Ensuring Continuity of Care

Under the Appropriations Act, if an individual is a "continuing care patient" (see below for definition) in relation to a provider or facility with a contractual relationship under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and

- the contractual relationship between the group health plan or group or individual health insurance issuer and a provider or facility is terminated;
- benefits provided under the plan or health insurance coverage with respect to the provider or facility are terminated because of a change in the terms of the participation of the provider or facility in the plan or coverage; or
- a contract between the group health plan and the health insurance issuer offering health insurance coverage in connection with the plan is terminated, resulting in a loss of benefits provided under the plan with respect to the provider or facility;

The plan or issuer must:

- notify each individual enrolled under the plan or coverage who is a continuing care patient with respect to the provider or facility at the time of a termination described above affecting the provider or facility on a timely basis of such termination and the individual's right to elect continued transitional care from the provider or facility;
- provide the individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and
- permit the individual to elect to continue to have benefits provided under the plan or coverage under the same terms and conditions as would have applied with respect to the items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by the provider or facility relating to the individual's status as a continuing care patient during the period beginning on the date on which the plan or issuer provides the notice described above and ending on the earlier of a) the 89th day following the day the plan or issuer provides the notice described above; or b) the date on which the individual is no longer a continuing care patient with respect to the provider or facility.

Note "termination" as used in this section does not include termination due to failure to meet quality standards or fraud.

A "continuing care patient" is an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
  - A serious and complex condition is a) an acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or b) a chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Reporting on Pharmacy Benefits, Drug Costs, and Other Health Care Services

Beginning no later than December 27, 2021, and no later than June 1 of each year after, a group health plan or health insurance issuer offering group or individual health insurance coverage (except for a church plan) must submit to the HHS, DOL, and the Treasury, the following information with respect to the health plan or coverage in the previous plan year:

- The start and end dates of the plan year.
- The number of enrollees.
- Each state in which the plan or coverage is offered.
- 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 such drug.
- The 50 most costly prescription drugs with respect to the plan or coverage by total annual spending, and the annual amount spent by the plan or coverage for each such drug.
- The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report (i.e., looking at the plan year that was two years ago compared to the previous plan year) and, for each such drug, the change in amounts expended by the plan or coverage in each of those plan years.
- Total spending on health care services by the group health plan or health insurance coverage, broken down by:
    - The type of costs, including a) hospital costs; b) health care provider and clinical service costs, for primary care and specialty care separately; c) costs for prescription drugs; and d) other medical costs, including wellness services; and
    - Spending on prescription drugs by the health plan or coverage; and the enrollees.
- The average monthly premium paid by employers on behalf of enrollees, as applicable; and paid by enrollees.
- Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers, with respect to prescription drugs prescribed to enrollees in the plan or coverage, including the amounts paid for each therapeutic class of drugs; and the amounts paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year.
- Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in the immediately preceding bullet point.

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