



Health and Welfare Plans 2022 Update

HHS Transparency Rule likely to require amendment to TPA confidentiality agreement provision

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The U.S. Department of Health and Human Services (HHS), along with the Internal Revenue Service (IRS) and U.S. Department of Labor (DOL), issued the Transparency in Coverage [final rule](#) in November 2020. This rule requires group health plans and health insurance issuers in the individual and group markets to take the following measures:

- Publicly disclose information about in-network and out-of-network provider rates, allowable amounts and billed charges (effective for plan years beginning on or after July 1, 2022);
- Provide consumers with cost-sharing information for 500 popular “shoppable” services online and make paper copies available upon request (effective for plan years beginning on or after January 1, 2023); and
- Disclose cost-sharing information upon request of a participant, beneficiary or enrollee for covered items or services furnished by a covered provider (effective for plan years beginning on or after January 1, 2024).

The Transparency in Coverage rule (“Transparency Rule”) is intended to increase transparency in health care pricing with the goal of bringing increased competition and lower prices to the private health care industry.

Group health plans sponsored by employers will have to make certain disclosures pursuant to the Transparency Rule. In many cases, vendors of a group health plan such as a third-party administrator (TPA) or a pharmacy benefit manager (PBM) will have the information and would be required to make the necessary disclosures. Such disclosures by a group health plan vendor may be precluded by a confidentiality provision, which is common in most

agreements between a group health plan or its sponsoring employer and the vendor. If the plan or sponsoring employer wishes to have its vendors make the necessary disclosures under the Transparency Rule, any confidentiality provision in the services agreement between such parties is likely to require an amendment allowing the vendor to disclose information as required under the Rule.

Fee disclosure requirement for group health plan service providers

The Employee Retirement Income Security Act (ERISA) was amended in December 2020 to require persons who provide brokerage services or consulting to group health plans to disclose specified information to a responsible plan fiduciary about the direct and indirect compensation that the service provider expects to receive for such services. The DOL issued guidance on such disclosure requirements in December 2021 as the disclosure requirements became effective on December 27, 2021. These disclosure requirements apply to insured and self-insured plans, regardless of the size of the plan.

The DOL guidance includes a temporary enforcement policy stipulating that a service provider will be considered to have made the required disclosures as long as the service provider made them in accordance with a good faith, reasonable interpretation of the ERISA disclosure requirement. The DOL also stated that taking into account the DOL's guidance on pension plan disclosure requirements when making the new group health plan disclosure would be viewed as a good faith and reasonable step. The DOL does not expect to issue comprehensive regulations on this issue, though additional guidance will be issued if considered necessary.

The DOL is particularly interested in the reporting of indirect compensation (e.g., referral fees paid to a service provider), noting in its guidance that recipients of indirect compensation should be prepared, in the event of an audit, to explain how a conclusion that they are not required to meet the disclosure requirements is consistent with a reasonable, good faith interpretation of ERISA.

Insurers and group health plans required to provide free Covid tests

HHS required insurance companies and group health plans to cover the cost of over-the-counter, at-home COVID-19 tests authorized, cleared, or approved by the U.S. Food and Drug Administration starting January 15, 2022. Most consumers with private health coverage can go online or to a pharmacy or store, buy a test, and either get it paid for upfront by their health plan or get reimbursed for the cost by submitting a claim to their plan. Individuals do not need an order from their health care provider to access these tests for free.

Insurance companies and health plans are required to cover the costs of eight (8) over-the-counter, at-home tests per covered individual per month. There is no limit on the number of tests, including at-home tests, that are covered if ordered or administered by a health care provider following an individualized clinical assessment.

Over-the-counter test purchases will be covered without the need for a health care provider's order and without any cost-sharing requirements such as deductibles, co-payments or coinsurance, prior authorization, or other medical management requirements.

HHS is incentivizing insurers and group health plans to set up programs that allow people to get over-the-counter tests directly through preferred pharmacies, retailers or other entities with no out-of-pocket costs. Through such programs, insurers and plans would cover the costs upfront, eliminating the need for consumers to submit a claim for reimbursement. Insurers and plans are still required to reimburse tests purchased by consumers outside of that network, at a rate of up to \$12 per individual test (or the cost of the test if less than \$12).

For more information or assistance updating health and wellness plans to comply with the foregoing, please contact the authors of this article. Learn more about Frost Brown Todd's Employee Benefits and ERISA practice group [here](#).

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