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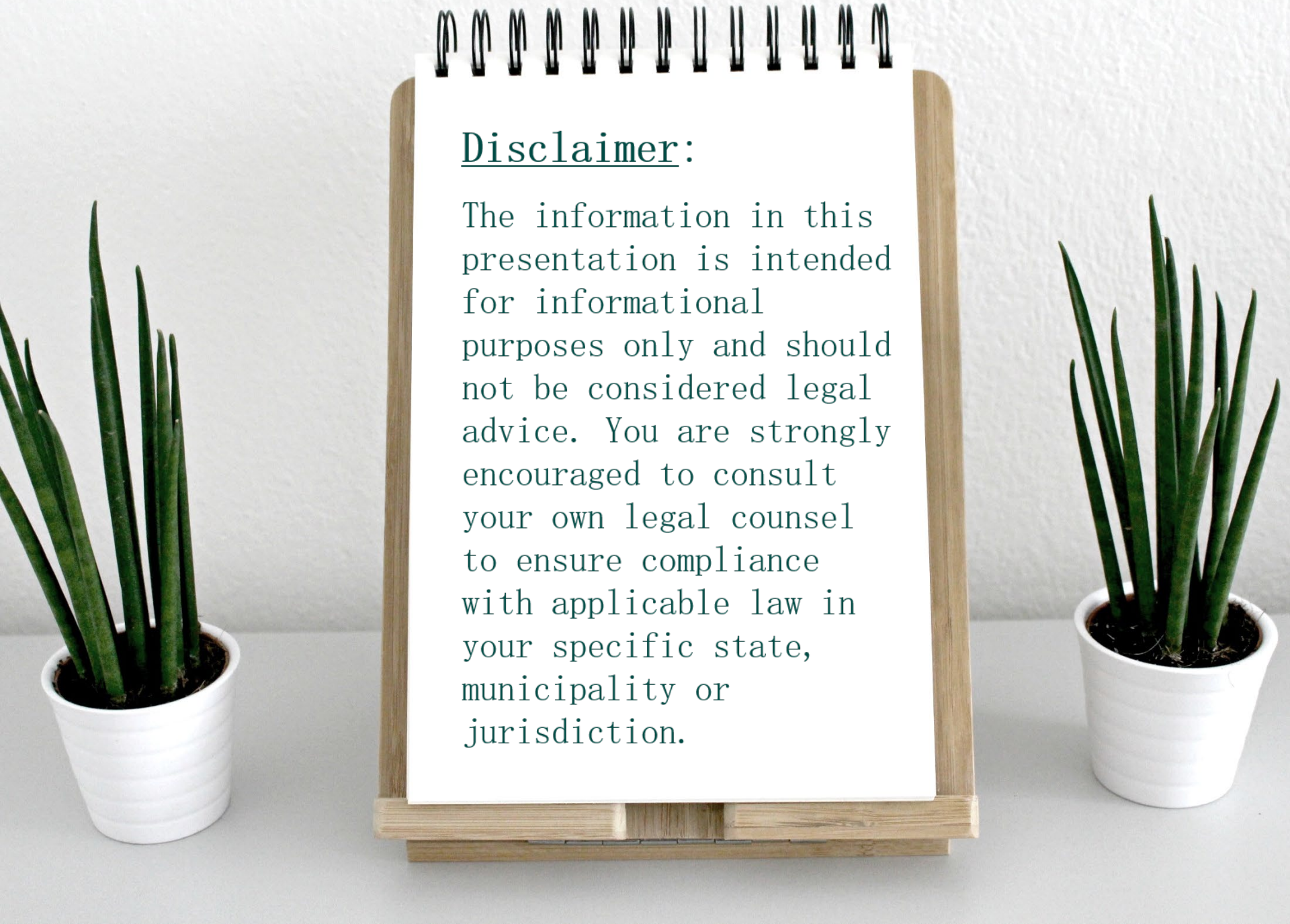
Benefits Compliance in 2022: Preparing for a New Year

January 20, 2022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Projects

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Today's Agenda:

- ✓ Transparency and Consumer Protection under the CAA
- ✓ COVID-19 Updates
- ✓ Policy Predictions
- ✓ Annual Compliance Obligations of Group Health Plans

Transparency and Consumer Protection under the CAA

The Consolidated Appropriations Act of 2021 (CAA) was signed into law on December 27, 2020. The spending bill is primarily aimed at providing economic relief in response to the COVID-19 public health emergency, but it also includes **a variety of measures focused on improving transparency and strengthening consumer protections** with respect to health insurance coverage:

- Surprise Billing Ban
- Pricing Transparency
- Prescription Drug Reporting
- Mental Health Parity Nonquantitative Treatment Limitations (NQTL) Comparative Analysis
- Group Health Plan Service Provider Disclosures

CAA Updates:
Surprise Billing

The No Surprises Act – "Surprise Billing"

Help protect consumers from unexpected medical bills resulting from a medical service where it was unlikely, they had known part of their care team was out-of-network (i.e., not contracted with their health plan). Generally, referred to as "surprise billing" or "balance billing."

Example:

Jane Doe needs routine knee surgery for a chronic condition. Jane schedules the surgery with an in-network surgeon at an in-network hospital. Following the surgery, she receives bills from an out-of-network radiologist, anesthesiologist, and surgery assistants. **$$$ Surprise!**

Applies to: Group health plans (fully insured and self-funded), health insurance carriers (for both group and individual plans), providers, and some facilities must comply with the rules. Plans of all sizes are included.

Transparency and Consumer Protection under the CAA

The No Surprises Act – "Surprise Billing" (cont'd)

Key Provisions:

To protect consumers from surprise billing, certain emergency care, air ambulance, and non-emergency care services cannot balance bill under the Act

- Emergency Care
  - *Services:* Emergency services and in some cases post-stabilization care
  - *Locations:* In & out-of-network emergency department located in a hospital, independent freestanding, and certain urgent care settings
  - *Member Liability:* In-network cost-share only (e.g., copay, deductible, coinsurance, out-of-pocket maximum)
- Air Ambulance
  - *Services:* In & out-of-network air ambulance services, if covered under the plan
  - *Member liability:* In-network cost-share only (e.g., copay, deductible, coinsurance, out-of-pocket maximum)

The No Surprises Act – "Surprise Billing" (cont'd)

Key Provisions (cont'd):

- Non-Emergency Care (cont'd)
  - *Services:* Certain out-of-network non-emergency services (Jane Doe Example)
  - *Location:* In-network facilities
  - *Member Liability:* In-network cost-share only (e.g., copay, deductible, coinsurance, out-of-pocket maximum)
    - Except when a member receives advanced notice of balance billing and provides written consent
    - Written consent cannot be requested when:
      - No in-network provider is available for the needed services
      - Receiving certain ancillary services, such as pathology, radiology, anesthesiology, assistant surgery services, laboratory, or diagnostic tests

Transparency and Consumer Protection under the CAA

The No Surprises Act – "Surprise Billing" (cont'd)

Key Provisions (cont'd):

- Required Notices
  - *Who:* Health plans and insurers
  - *What:* Requirements, prohibitions, state balance billing rules, and who to contact to file a complaint
  - *Where:* Post on the benefits website and include with EOBs
  - *How:* Model notice is available on the DOL website (download)
- Not Covered in this Presentation
  - Provider charge limitations
  - Independent claims dispute resolution

Effective Date: For group health plans and insurance carriers, the rules go into effect for the plan and policy years beginning on or after January 1, 2022. The HHS-only regulations that apply to health care providers, facilities, and providers of air ambulance services are applicable beginning on January 1, 2022.

Transparency and Consumer Protection under the CAA

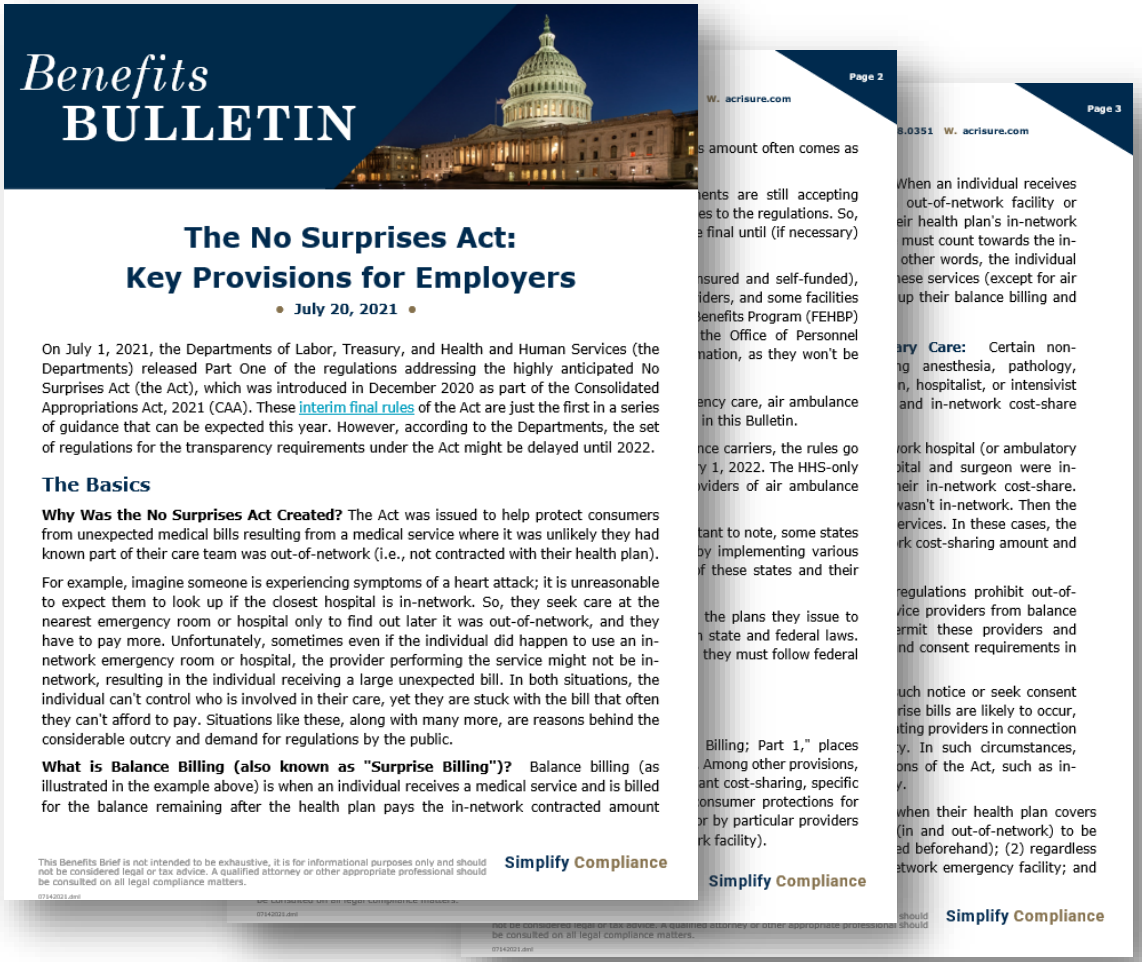
The No Surprises Act – "Surprise Billing" (cont'd)

Action Items:

- Consult with trusted advisors (e.g., benefits attorneys, consultants, CPA service providers, etc.)
- For **fully-insured health plans**, confirm which provisions will be handled by the insurance carrier
- For **self-insured health plans**, work with TPAs, rental network providers, and others for assistance implementing these new rules
- Update documents
  - Plan communications (e.g., enrollment kits, new hire packets, etc.) to include the new notice requirements
  - Review and update plan SPD, if necessary
  - Collect the insurance carrier's updated policy, certificate of coverage (aka, member booklet), and other plan documents which describe the services included in the Act

Transparency and Consumer Protection under the CAA

The No Surprises Act – "Surprise Billing" (cont'd)



Benefits BULLETIN

The No Surprises Act:
Key Provisions for Employers

• July 20, 2021 •

On July 1, 2021, the Departments of Labor, Treasury, and Health and Human Services (the Departments) released Part One of the regulations addressing the highly anticipated No Surprises Act (the Act), which was introduced in December 2020 as part of the Consolidated Appropriations Act, 2021 (CAA). These interim final rules of the Act are just the first in a series of guidance that can be expected this year. However, according to the Departments, the set of regulations for the transparency requirements under the Act might be delayed until 2022.

The Basics

Why Was the No Surprises Act Created? The Act was issued to help protect consumers from unexpected medical bills resulting from a medical service where it was unlikely they had known part of their care team was out-of-network (i.e., not contracted with their health plan).

For example, imagine someone is experiencing symptoms of a heart attack; it is unreasonable to expect them to look up if the closest hospital is in-network. So, they seek care at the nearest emergency room or hospital only to find out later it was out-of-network, and they have to pay more. Unfortunately, sometimes even if the individual did happen to use an in-network emergency room or hospital, the provider performing the service might not be in-network, resulting in the individual receiving a large unexpected bill. In both situations, the individual can't control who is involved in their care, yet they are stuck with the bill that often they can't afford to pay. Situations like these, along with many more, are reasons behind the considerable outcry and demand for regulations by the public.

What is Balance Billing (also known as "Surprise Billing")? Balance billing (as illustrated in the example above) is when an individual receives a medical service and is billed for the balance remaining after the health plan pays the in-network contracted amount

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Resources:

Benefits Bulletin

DOL Website (No Surprises Act Page)

No Surprises Act, Interim Final Regulations Part I

No Surprises Act, Interim Final Regulations Part II

FAQs Addressing Implementation of the No Surprises Act. (Part 49)

CMS Technical Guidance No. 2021-01, Federal Independent Dispute Resolution Process

Fact Sheet for Group Health Plans and Health Insurance Issuers

CAA Updates: Pricing Transparency

Transparency Requirements in the CAA

Topics Covered in this Presentation

- ID Card Requirements
- Advanced Explanation of Benefits
- Price Comparison Tool
- Provider Directories
- Choice of Healthcare Professionals (PCPs)
- Continuity of Care Requirements
- Protections Against Provider Discrimination

Topics Not Covered in this Presentation

- Prohibition on Gag Clauses (contracts after December 27, 2020)
- Public Pricing Information Disclosures*
- Negotiated In-Network and Out-of-Network Allowed Amounts*

*Not part of the CAA – Other Transparency Regulations

Transparency and Consumer Protection under the CAA

Pricing Transparency

Applies to: Group health plans (fully insured and self-funded) and individual health plans must comply with the rules. Plans of all sizes are included.

Key Provisions:

- ID Card Requirements
  - Physical or electronic ID cards must disclose:
    - In-network & out-of-network deductibles
    - Any out-of-pocket maximum
    - Telephone # & website for further assistance
  - Effective January 1, 2022
- Advanced Explanation of Benefits (EOB) for Scheduled Services
  - Must be requested
  - Issued no later than 1 day after the date of such scheduling (if the scheduling occurs at least 3 days before the date the service is to be provided) or not later than 3 business days after the date of scheduling (if the scheduling occurs at least 10 days before the date the service is to be provided)

Pricing Transparency (cont'd)

Key Provisions (cont'd):

- Advanced Explanation of Benefits (EOB) for Scheduled Services (cont'd)
  - EOB must include (not exhaustive list)
    - Provider or facility network status
      - In-network contracted rate (based on billing and diagnostic codes);
      - Out-of-network service, include how to obtain information on in-network providers of those services
    - Good faith estimate of:
      - Cost of service
      - Amount the Plan will pay
      - Any cost-sharing the member must pay
      - Amount the member has incurred toward meeting their deductible and out-of-pocket maximum
  - Delayed enforcement until regulations & guidance are issued

Pricing Transparency (cont'd)

Key Provisions (cont'd):

- Price Comparison Tool
  - Guidance (via phone) or tool (via website) providing price comparison of cost-sharing that a member would be responsible to pay for a specific item or service factoring in the Plan Year, Geographic Region, or Participating Providers
  - 500 most common "shoppable" expenses – Plan Year January 1, 2023
  - All covered expenses – Plan Year January 1, 2024
- Provider Directories
  - Ensure directories are accurate and kept current with updates every 90-days
  - Easily accessible online or by phone
  - Effective January 1, 2022

Pricing Transparency (cont'd)

Key Provisions (cont'd):

- Continuity of Care Requirements
  - "Continuing Care Patient" – individual receiving certain care from an in-network provider or facility, such as:
    - Treatment for a serious and complex condition (both in-patient and out-patient care)
    - Scheduled for nonelective surgery
    - Pregnant and receiving treatment for pregnancy
    - Terminally ill and receiving treatment for such illness
  - Health plan must continue the provider care as in-network for 90-days following the provider's change to out-of-network status, or 90-days following the individual's change to a non-continuing care patient status (whichever is earlier)
  - Effective on January 1, 2022

Transparency and Consumer Protection under the CAA

Pricing Transparency (cont'd)

Key Provisions (cont'd):

- Choice of Healthcare Professionals (PCPs)
  - Extends the current ACA provision to grandfathered plans
  - Plans requiring the designation of a PCP can't restrict a member from selecting any in-network provider as their PCP or any in-network pediatrician for their child
  - Plan can't require a female member to obtain a preauthorization or referral to receive care from an in-network obstetrician or gynecologist and referrals from these providers must be treated the same as those from a PCP
  - Notice of these rights must be included in the plan's SPD

- Protections Against Provider Discrimination
  - Prohibits discrimination against "any willing provider"
  - Aims to clarify a provision in the ACA
  - Proposed regulations were due no later than January 1, 2022, with final regulations due no later than six months after comments are received – still waiting on proposed regulations

Effective Date: Varies by Provision as stated by each above

Transparency and Consumer Protection under the CAA

Pricing Transparency (cont'd)

Action Items

- Don't rely on any current requests for delayed enforcement or phase-in periods – continue to take action!
- For **fully-insured health plans**, confirm which provisions will be handled by the insurance carrier
- For **self-insured health plans**, work with TPAs, rental network providers, and others for assistance implementing these new rules
- Update plan documents and communications *(if necessary)*
  - Summary Plan Descriptions (SPDs)
  - Summary of Benefits Coverage (SBCs)
  - Benefits Communications (including websites) & Enrollment Kits
- Post the Balance Billing Protections Notice (DOL model notice)

CAA Updates: Prescription Drug Reporting

Prescription Drug Reporting

Applies to: Requires employers (self-insured) and insurers (carriers) to report to the DOL, IRS, & HHS certain information regarding costs associated with the prescription drug benefits.

Key Provisions

- First report was due on 12/27/21 with annual reporting due on 6/1
  - Reports must include:
    - Plan year
    - # of participants & beneficiaries
    - State plan is offered in
    - Top 50
      - Dispensed brand prescription drugs & # claims
      - Most expensive prescription drugs by annual spend
      - Prescription drugs with the highest increase in plan expenditures

Transparency and Consumer Protection under the CAA

Prescription Drug Reporting (cont'd)

Key Provisions (cont'd)

- Reports must include (cont'd):
  - Total spend broken down by health care service type
  - Average monthly premiums paid by employees and employer
  - Rebates, fees, and other remuneration paid by drug manufacturers to the plan and any reduction in premiums or out-of-pocket costs as it relates to rebates
- HHS will publicly post de-identified aggregate reports on their website
  - Prescription drug reimbursements under health plans
  - Prescription drug pricing trends
  - Contribution of prescription drug costs to premium increases (decreases – ha!) under such plans

Effective Date: December 27, 2021 (enforcement delayed until December 27, 2022 – at such time reports must include 2020 & 2021)

Transparency and Consumer Protection under the CAA

Prescription Drug Reporting (cont'd)

Action Items

- **Fully-insured health plans:**
  - While generally, the requirement obligation will fall on the carriers, it is wise for employers to discuss it with them.
  - If an employer has a fully insured medical plan but carves out the prescription drugs then the reporting obligation falls on the employer.
- **Self-insured health plans:**
  - Employers need to discuss reporting requirements with all sources of the data needed, such as TPAs and PBMs.
    - Ability to supply all data needed
    - Timeline
    - Assistance with filing reports
    - Any additional fees for their assistance
    - Update service agreements

CAA Updates: Mental Health Parity NQTL

Mental Health Parity (MHP) NQTL Comparative Analysis

Applies to: Group health plans and health insurers that offer mental health and/or substance use disorder benefits

- Insured and self-insured arrangements (unless the self-insured plan has followed the opt-out procedures)
- Plans of all sizes, though an exemption is available for plans maintained by a small employer
- Does not apply to retiree-only plans

Key Provisions

- MHP requires parity between mental health and/or substance use disorder benefits and medical and surgical benefits
  - Annual and lifetime limits
  - Financial requirements and quantitative treatment limits
  - Nonquantitative treatment limitations

Transparency and Consumer Protection under the CAA

Mental Health Parity (MHP) NQTL Comparative Analysis (cont'd)

Key Provisions (cont'd)

- A plan may not impose a NQTL on a mental health or substance use disorder benefit unless any processes, standards, or strategies are comparable to and applied no more stringently than those used in applying the limitation to medical and surgical benefits
- The comparative analysis is designed to confirm whether the plan is within parity
- MHP already required group health plans and insurers to perform an analysis of NQTLs, but the CAA requires plans to produce *written documentation* detailing the analysis
- The written analysis must be provided to the DOL, IRS or HHS upon request; these agencies are tasked to collect at least 20 analyses per year

Effective Date: February 10, 2021

Transparency and Consumer Protection under the CAA

Mental Health Parity (MHP) NQTL Comparative Analysis (cont'd)

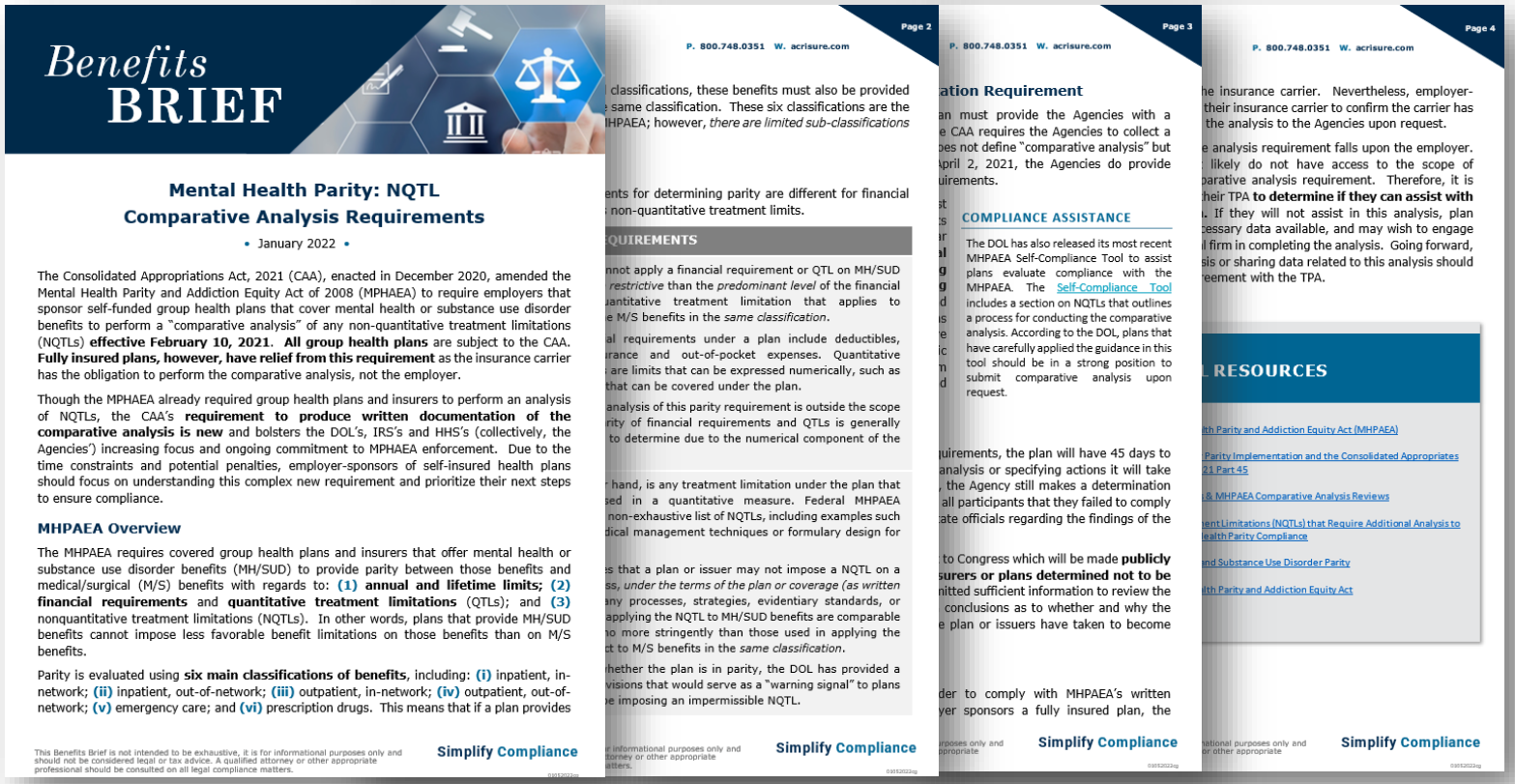
Action Items

- For **fully-insured health plans**, the NQTL comparative analysis requirement falls upon the health insurer; there is no action required by the employer-sponsor
- For **self-insured health plans**, the analysis requirement falls upon the employer-sponsor
  - First, contact the plan's TPA or ASO to determine whether they'll complete the analysis
  - If not, the TPA/ASO should be prepared to provide access to the data that will be necessary to complete the analysis
  - The DOL makes available a Self-Compliance Tool that guides a plan through the process of conducting an analysis
  - The employer will likely want to engage assistance, such as through outside counsel or an actuarial firm
  - Going forward, completion of the analysis should be detailed in any TPA/ASO contract for services

Transparency and Consumer Protection under the CAA

Mental Health Parity (MHP) NQTL Comparative Analysis (cont'd)

Benefits Brief (download)



Benefits BRIEF

Mental Health Parity: NQTL Comparative Analysis Requirements

• January 2022 •

The Consolidated Appropriations Act, 2021 (CAA), enacted in December 2020, amended the Mental Health Parity and Addiction Equity Act of 2008 (MPHAEA) to require employers that sponsor self-funded group health plans that cover mental health or substance use disorder benefits to perform a "comparative analysis" of any non-quantitative treatment limitations (NQTLs) **effective February 10, 2021**. **All group health plans** are subject to the CAA. **Fully insured plans, however, have relief from this requirement** as the insurance carrier has the obligation to perform the comparative analysis, not the employer.

Though the MPHAEA already required group health plans and insurers to perform an analysis of NQTLs, the CAA's **requirement to produce written documentation of the comparative analysis is new** and bolsters the DOL's, IRS's and HHS's (collectively, the Agencies') increasing focus and ongoing commitment to MPHAEA enforcement. Due to the time constraints and potential penalties, employer-sponsors of self-insured health plans should focus on understanding this complex new requirement and prioritize their next steps to ensure compliance.

MHPAEA Overview

The MHPAEA requires covered group health plans and insurers that offer mental health or substance use disorder benefits (MH/SUD) to provide parity between those benefits and medical/surgical (M/S) benefits with regards to: **(1) annual and lifetime limits; (2) financial requirements** and **quantitative treatment limitations** (QTLs); and **(3)** nonquantitative treatment limitations (NQTLs). In other words, plans that provide MH/SUD benefits cannot impose less favorable benefit limitations on those benefits than on M/S benefits.

Parity is evaluated using **six main classifications of benefits**, including: **(i)** inpatient, in-network; **(ii)** inpatient, out-of-network; **(iii)** outpatient, in-network; **(iv)** outpatient, out-of-network; **(v)** emergency care; and **(vi)** prescription drugs. This means that if a plan provides

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classifications, these benefits must also be provided same classification. These six classifications are the HPAEA; however, *there are limited sub-classifications*

nts for determining parity are different for financial non-quantitative treatment limits.

QUIREMENTS

nnot apply a financial requirement or QTL on MH/SUD *restrictive* than the *predominant level* of the financial uantitative treatment limitation that applies to e M/S benefits in the *same classification*.

al requirements under a plan include deductibles, urance and out-of-pocket expenses. Quantitative are limits that can be expressed numerically, such as that can be covered under the plan.

analysis of this parity requirement is outside the scope rity of financial requirements and QTLs is generally to determine due to the numerical component of the

hand, is any treatment limitation under the plan that sed in a quantitative measure. Federal MHPAEA non-exhaustive list of NQTLs, including examples such dical management techniques or formulary design for

s that a plan or issuer may not impose a NQTL on a ss, *under the terms of the plan or coverage (as written* ny processes, strategies, evidentiary standards, or applying the NQTL to MH/SUD benefits are comparable o more stringently than those used in applying the t to M/S benefits in the *same classification*.

hether the plan is in parity, the DOL has provided a visions that would serve as a "warning signal" to plans e imposing an impermissible NQTL.

informational purposes only and torney or other appropriate atters.

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ation Requirement

an must provide the Agencies with a e CAA requires the Agencies to collect a es not define "comparative analysis" but April 2, 2021, the Agencies do provide uirements.

COMPLIANCE ASSISTANCE

The DOL has also released its most recent MHPAEA Self-Compliance Tool to assist plans evaluate compliance with the MHPAEA. The Self-Compliance Tool includes a section on NQTLs that outlines a process for conducting the comparative analysis. According to the DOL, plans that have carefully applied the guidance in this tool should be in a strong position to submit comparative analysis upon request.

uirements, the plan will have 45 days to analysis or specifying actions it will take , the Agency still makes a determination all participants that they failed to comply ate officials regarding the findings of the

to Congress which will be made **publicly surers or plans determined not to be** itted sufficient information to review the conclusions as to whether and why the e plan or issuers have taken to become

der to comply with MHPAEA's written yer sponsors a fully insured plan, the

urposes only and appropriate

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he insurance carrier. Nevertheless, employer- their insurance carrier to confirm the carrier has the analysis to the Agencies upon request.

e analysis requirement falls upon the employer. likely do not have access to the scope of parative analysis requirement. Therefore, it is heir TPA **to determine if they can assist with** . If they will not assist in this analysis, plan cessary data available, and may wish to engage firm in completing the analysis. Going forward, sis or sharing data related to this analysis should eement with the TPA.

RESOURCES

th Parity and Addiction Equity Act (MHPAEA)

Parity Implementation and the Consolidated Appropriates 21 Part 45

& MHPAEA Comparative Analysis Reviews

ent Limitations (NQTLs) that Require Additional Analysis to ealth Parity Compliance

nd Substance Use Disorder Parity

th Parity and Addiction Equity Act

ational purposes only and or other appropriate

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CAA Updates: Service Provider Disclosures

Group Health Plan Service Provider Disclosures

Applies to: ERISA-covered group health plans, including medical, dental, and vision plans, as well as Health FSAs, HRAs, EAPs, and wellness programs

- Insured and self-insured arrangements
- Plans of all sizes; there is no size threshold

Key Provisions: To comply with ERISA's prohibited transaction rules, plan sponsors must ensure that compensation paid to plan service providers is reasonable. The new disclosure requirement is intended to provide plan sponsors with this necessary information.

- The disclosure requirement is triggered where the service provider expects to receive $1,000 or more in direct or indirect compensation
  - Compensation paid to a service provider directly by the employer is **not** subject to this disclosure requirement
- Disclosures must include a description of the services provided and an estimate of all direct and indirect compensation the service provider expects to receive for performing these services

Group Health Plan Service Provider Disclosures (cont'd)

Effective Date: December 27, 2021

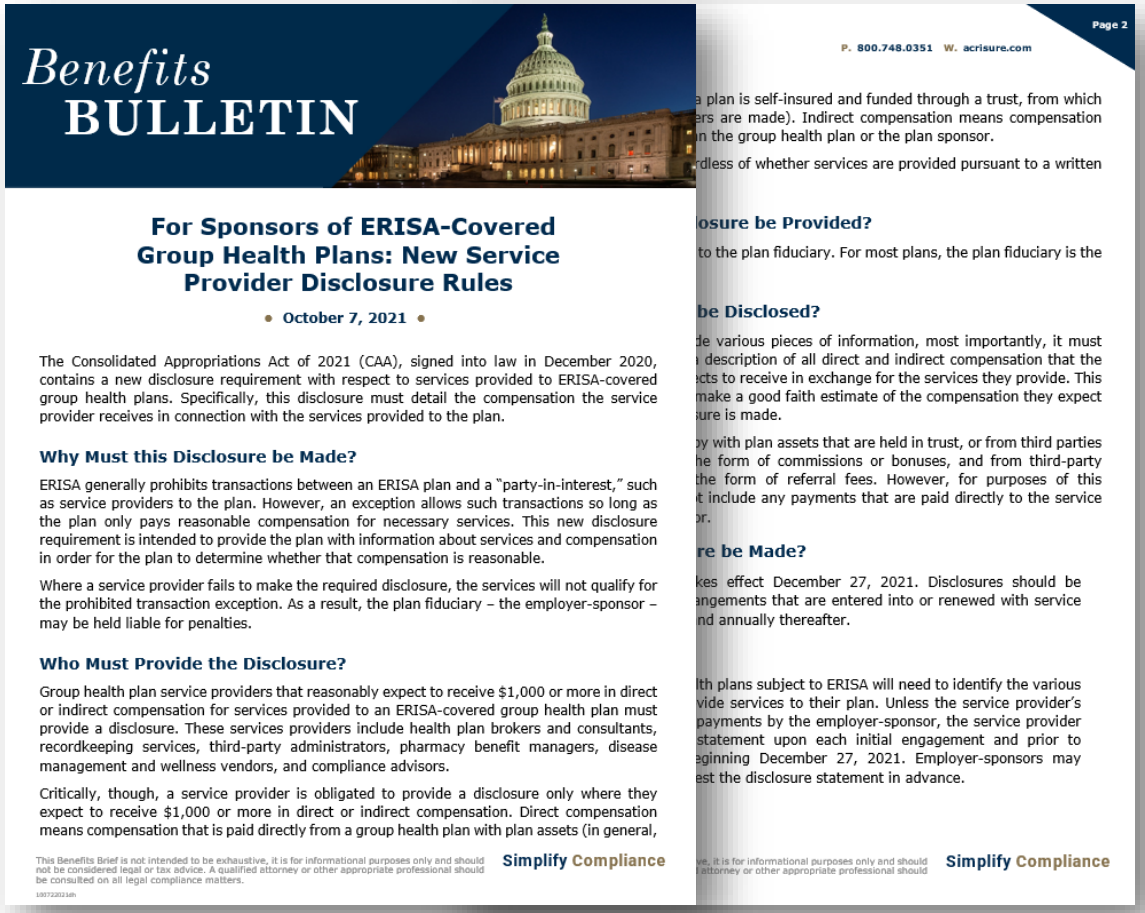
- Contracts or arrangements formed or renewed on/after this date
- Due to a lack of guidance from the DOL, service providers are tasked with making a **good faith effort** to comply in 2022, which is likely to result in reasonable variations from one service provider to another

Action Items: In 2022, employer-sponsors of ERISA group health plans should begin to:

- Identify the individuals and entities who provide services to the group health plan, regardless of whether those services are provided pursuant to a contract
- Where a service provider receives compensation from a source other than the employer-sponsor, inquire about the process for distributing disclosures
- Disclosures do not need to be filed with any state or federal agency, but employer-sponsors should keep the disclosure with its group health plan records; it may need to be presented in the event of an audit

Group Health Plan Service Provider Disclosures (cont'd)

Benefits Bulletin (download)



Benefits BULLETIN

For Sponsors of ERISA-Covered Group Health Plans: New Service Provider Disclosure Rules

• October 7, 2021 •

The Consolidated Appropriations Act of 2021 (CAA), signed into law in December 2020, contains a new disclosure requirement with respect to services provided to ERISA-covered group health plans. Specifically, this disclosure must detail the compensation the service provider receives in connection with the services provided to the plan.

Why Must this Disclosure be Made?

ERISA generally prohibits transactions between an ERISA plan and a "party-in-interest," such as service providers to the plan. However, an exception allows such transactions so long as the plan only pays reasonable compensation for necessary services. This new disclosure requirement is intended to provide the plan with information about services and compensation in order for the plan to determine whether that compensation is reasonable.

Where a service provider fails to make the required disclosure, the services will not qualify for the prohibited transaction exception. As a result, the plan fiduciary – the employer-sponsor – may be held liable for penalties.

Who Must Provide the Disclosure?

Group health plan service providers that reasonably expect to receive $1,000 or more in direct or indirect compensation for services provided to an ERISA-covered group health plan must provide a disclosure. These services providers include health plan brokers and consultants, recordkeeping services, third-party administrators, pharmacy benefit managers, disease management and wellness vendors, and compliance advisors.

Critically, though, a service provider is obligated to provide a disclosure only where they expect to receive $1,000 or more in direct or indirect compensation. Direct compensation means compensation that is paid directly from a group health plan with plan assets (in general,

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a plan is self-insured and funded through a trust, from which ers are made). Indirect compensation means compensation n the group health plan or the plan sponsor.

rdless of whether services are provided pursuant to a written

losure be Provided?

to the plan fiduciary. For most plans, the plan fiduciary is the

be Disclosed?

de various pieces of information, most importantly, it must description of all direct and indirect compensation that the cts to receive in exchange for the services they provide. This make a good faith estimate of the compensation they expect ure is made.

y with plan assets that are held in trust, or from third parties he form of commissions or bonuses, and from third-party the form of referral fees. However, for purposes of this t include any payments that are paid directly to the service or.

re be Made?

kes effect December 27, 2021. Disclosures should be angements that are entered into or renewed with service nd annually thereafter.

th plans subject to ERISA will need to identify the various vide services to their plan. Unless the service provider's payments by the employer-sponsor, the service provider statement upon each initial engagement and prior to eginning December 27, 2021. Employer-sponsors may est the disclosure statement in advance.

ve, it is for informational purposes only and should attorney or other appropriate professional should

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COVID-19 Updates

Coverage Mandates

The Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act include certain COVID-19-related coverage requirements on group health plans and health insurers. Coverage must be provided without cost-sharing or prior authorization requirements.

- **Diagnostic Testing**
- **Over-the-Counter (OTC) Tests** (8 per month, effective January 15)
- **Vaccines**

States may enact additional coverage requirements that go beyond those mandated by federal law. These state requirements apply only to insured health plans; self-insured health plans are exempt but may choose to comply on a voluntary basis.

Vaccination Incentives

With the Supreme Court's January 13 decision to block President Biden's "vaccine-or-testing" mandate, employers may find renewed interest in exploring ways to increase vaccination rates in the workplace, including the offering of incentives through a wellness program.

Wellness program requirements are complex, but there are **three main rules employers must consider when implementing vaccination incentives**:

- HIPAA's Nondiscrimination Exception for Wellness Programs
- The ADA's Voluntary Standard
- The ACA's affordability calculation

Vaccination Incentives (cont'd)

HIPAA's Nondiscrimination Exception for Wellness Programs requires employers to implement a wellness program in order to incentivize vaccinations through the application of a premium discount or surcharge.

- **Reward Frequency**: Provide individuals an opportunity to qualify for the reward at least once per year
- **Reward Size**: The reward cannot exceed 30% of the cost of coverage under the plan (can be up to 50% where the additional percentage is in connection with a tobacco-cessation program)
- **Reasonable Design**: Must be designed to promote health
- **Uniform Availability and Reasonable Alternative Standard**: Must allow a reasonable alternative standard (or wavier of standard) for any individual for whom it is unreasonably difficult or inadvisable due to a medical condition
- **Notice of Availability**: The plan must disclose the availability of the reasonable alternative standard

Vaccination Incentives (cont'd)

A program that directly provides or administers the COVID-19 vaccine to employees (by either the employer or a third party acting on the employer's behalf) must comply with the **ADA's voluntary standard**.

- Participation in the program cannot be required
- Coverage under a group health plan or benefit package is not denied or limited for non-participation
- No coercion or adverse employment action is taken against employees who decline to participate
- The required ADA notice is provided to employees
- **Incentives or rewards do not exceed the prescribed 30% cost-of-coverage maximum**.

These requirements were promulgated by the Equal Employment Opportunity Commission (EEOC) in 2016. In the time since, the fifth requirement related to reward size has evolved considerably.

Vaccination Incentives (cont'd)

Applicable Large Employers remain subject to the ACA's employer shared responsibility rules, including the requirement to offer affordable health coverage to full-time employees.

Impact of Incentives and Rewards on **Affordability under the ACA**:

- Non-tobacco incentives and rewards cannot be factored into the monthly cost of coverage for purposes of determining affordability
- This means that the cost of coverage without the premium reduction, or the cost of coverage with the premium surcharge, must comply with the ACA's affordability guidelines (9.61% in 2022).

Ongoing DOL Administrative Relief

In April 2020, the U.S. DOL released guidance for employee benefit plans that temporarily requires the extension of certain administrative timeframes effective March 1, 2020. The goal is to minimize the possibility of individuals losing coverage during the public health emergency. This relief is ongoing, though it has been modified (EBSA Disaster Relief Notice).

Plan sponsors must **toll deadlines until the earlier of**: 1). one year from the date the individual was first eligible for relief; or 2). 60 days following the announced end of the public health emergency.

- **COBRA Timeframes**
  - The 60-day election period
  - Premium payment deadlines
  - Notifications to the plan of a qualifying event or disability determination
  - The distribution of an Election Notice to a qualified beneficiary

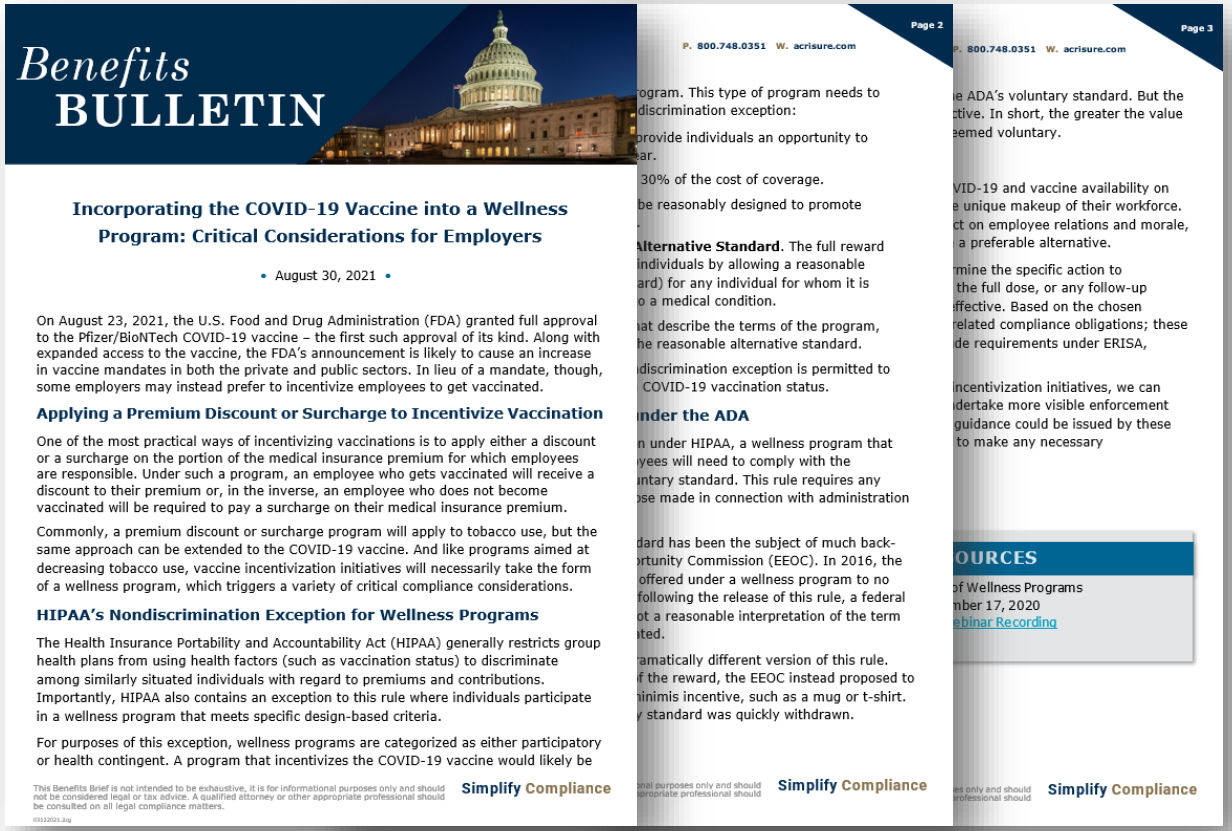
Ongoing DOL Administrative Relief (cont'd)

- **HIPAA Special Enrollment Timeframes**
- **Claims Procedure and External Review Process Timeframes**
  - The date within which individuals may file a claim
  - The date within which claimants may file an appeal
  - The date within which a claimant may file a request for an external review or file information to perfect such a request

Coordination with insurance carriers (including stop-loss carriers) and TPAs continues to be critical, particularly with respect to administering retroactive enrollments under COBRA and HIPAA.

Incorporating the COVID-19 Vaccine into a Wellness Program: Critical Considerations for Employers

Benefits Bulletin (download)



Benefits **BULLETIN**

Incorporating the COVID-19 Vaccine into a Wellness Program: Critical Considerations for Employers

• August 30, 2021 •

On August 23, 2021, the U.S. Food and Drug Administration (FDA) granted full approval to the Pfizer/BioNTech COVID-19 vaccine – the first such approval of its kind. Along with expanded access to the vaccine, the FDA's announcement is likely to cause an increase in vaccine mandates in both the private and public sectors. In lieu of a mandate, though, some employers may instead prefer to incentivize employees to get vaccinated.

Applying a Premium Discount or Surcharge to Incentivize Vaccination

One of the most practical ways of incentivizing vaccinations is to apply either a discount or a surcharge on the portion of the medical insurance premium for which employees are responsible. Under such a program, an employee who gets vaccinated will receive a discount to their premium or, in the inverse, an employee who does not become vaccinated will be required to pay a surcharge on their medical insurance premium.

Commonly, a premium discount or surcharge program will apply to tobacco use, but the same approach can be extended to the COVID-19 vaccine. And like programs aimed at decreasing tobacco use, vaccine incentivization initiatives will necessarily take the form of a wellness program, which triggers a variety of critical compliance considerations.

HIPAA's Nondiscrimination Exception for Wellness Programs

The Health Insurance Portability and Accountability Act (HIPAA) generally restricts group health plans from using health factors (such as vaccination status) to discriminate among similarly situated individuals with regard to premiums and contributions. Importantly, HIPAA also contains an exception to this rule where individuals participate in a wellness program that meets specific design-based criteria.

For purposes of this exception, wellness programs are categorized as either participatory or health contingent. A program that incentivizes the COVID-19 vaccine would likely be

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Legislative Activity: Policy Predictions

The Affordable Care Act

- The Supreme Court's decision in ***California v. Texas***
  - Argued in November 2020, this case centered on the constitutionality of the individual mandate and the viability of the ACA in whole
  - The June 2021 decision did not rule on the merits of the case but nevertheless upheld the law in its current form – including the employer shared responsibility rules
  - Future legal challenges, if any, will likely be more nuanced and without sweeping implications
- Build Back Better Bill
  - **Expanded Subsidies**
    - Extends expanded eligibility parameters under the American Rescue Plan Act (ARPA)
  - **Fixed Affordability Threshold**
    - The affordability percentage under the employer shared responsibility rules will be decreased and fixed at 8.5%

Policy Predictions

Employee Benefits

- Build Back Better Bill
  - **Mental Health Parity Compliance**
    - Grants the DOL the authority to assess civil penalties of $100 per day for MHP violations
    - Assessable to insurers and group health plans
- Notable Absences
  - **Telehealth + HDHPs**
    - The CARES Act provided **temporary** relief for high-deductible health plans (HDHPs) to cover cost-free telehealth without jeopardizing the HDHP status of the plan
    - This relief applies only to plan years beginning on or before December 31, 2021
  - Increased Contribution Limit for **Dependent Care Assistance**
    - ARPA temporarily increased the DCAP contribution limit to $10,500 for 2021
    - A permanent increase to $10,000 was originally included in Build Back Better

Policy Predictions

Prescription Drug Reform

- Build Back Better Bill
  - **Medicare negotiation** on pricing of high-cost prescription drugs
  - Tax **penalty imposition on manufacturers** whose drug prices increase faster than inflation
  - Medicare Part D **OOP limit capped** at $2,000 annually with a specific copay cap for insulin
  - **PBM Disclosures**
    - Amount of manufacturer assistance and rebates
    - Listing of drugs dispensed and associated costs
- Other Popular Initiatives
  - **Importation** of drugs from other countries
  - Expanding availability of **generic formulations**

Other Legislation of Interest

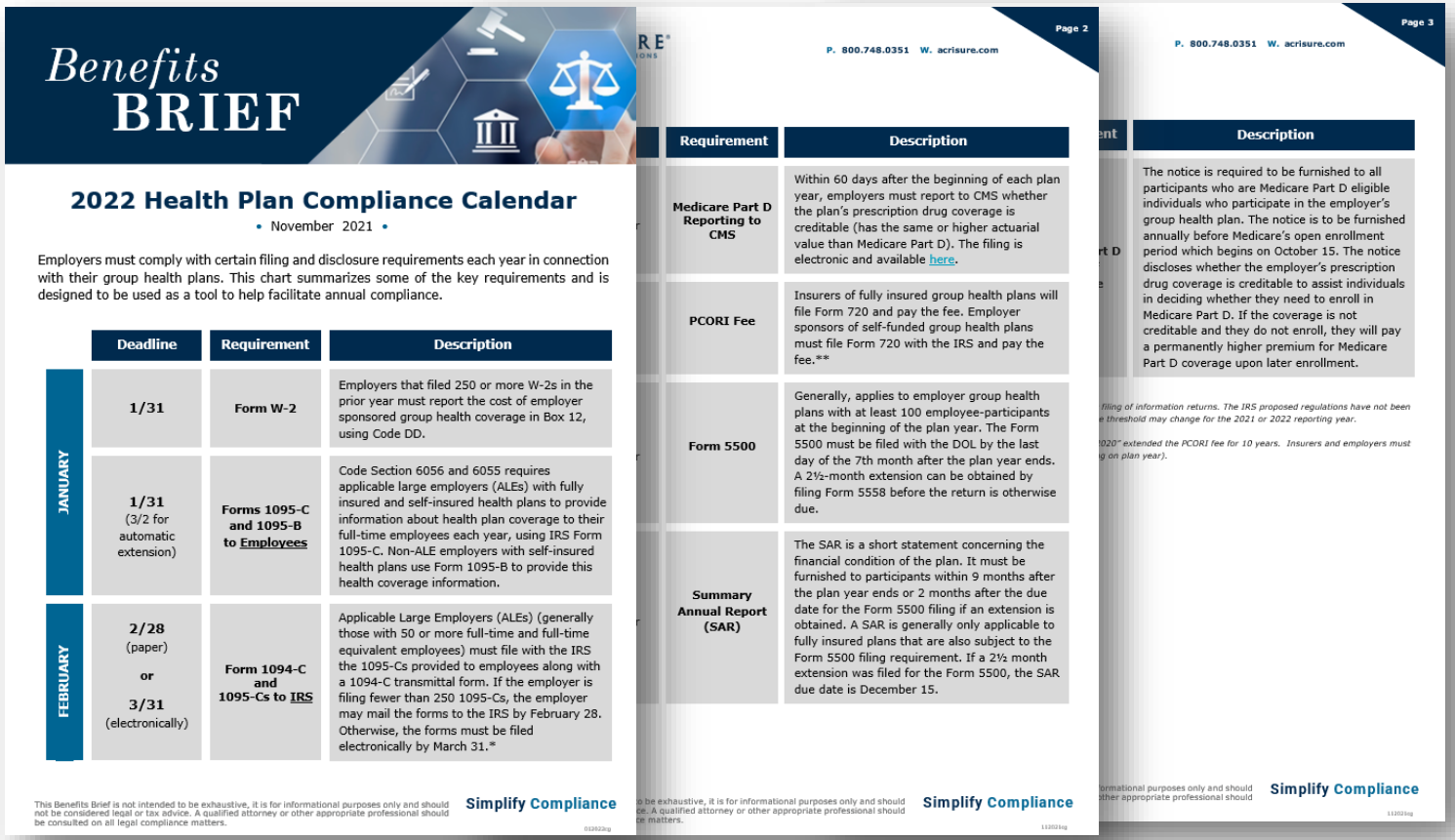
- **Commonsense Reporting Act** (HR 5318)
  - Introduced in September 2021, Rep. Thompson (D-CA)
  - A streamlined reporting process for verification of eligibility for premium tax credits wherein employer information is submitted prior to open enrollment season rather than year-end tax season
- **The Personal Health Investment Today Act** (HR 1679)
  - Introduced in March 2021, Sen. Thune (R-SD)
  - Would recognize sports and fitness expenses as qualified eligible expenses under pre-tax savings arrangements, including HSAs and Health FSAs
- **Protection from Obamacare Mandates and Congressional Equity Act** (HR 64)
  - Introduced in January 2021, Rep. Biggs (R-AZ)
  - Would exempt from the individual mandate persons residing in counties with fewer than two insurers offering plans on an Exchange

Annual Compliance Obligations

Annual Compliance Obligations of Group Health Plans

2022 Health Plan Compliance Calendar

Benefits Brief (download)



Benefits BRIEF

2022 Health Plan Compliance Calendar

• November 2021 •

Employers must comply with certain filing and disclosure requirements each year in connection with their group health plans. This chart summarizes some of the key requirements and is designed to be used as a tool to help facilitate annual compliance.

	Deadline	Requirement	Description
JANUARY	1/31	Form W-2	Employers that filed 250 or more W-2s in the prior year must report the cost of employer sponsored group health coverage in Box 12, using Code DD.
JANUARY	1/31 (3/2 for automatic extension)	Forms 1095-C and 1095-B to Employees	Code Section 6056 and 6055 requires applicable large employers (ALEs) with fully insured and self-insured health plans to provide information about health plan coverage to their full-time employees each year, using IRS Form 1095-C. Non-ALE employers with self-insured health plans use Form 1095-B to provide this health coverage information.
FEBRUARY	2/28 (paper) or 3/31 (electronically)	Form 1094-C and 1095-Cs to IRS	Applicable Large Employers (ALEs) (generally those with 50 or more full-time and full-time equivalent employees) must file with the IRS the 1095-Cs provided to employees along with a 1094-C transmittal form. If the employer is filing fewer than 250 1095-Cs, the employer may mail the forms to the IRS by February 28. Otherwise, the forms must be filed electronically by March 31.*

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Requirement	Description
Medicare Part D Reporting to CMS	Within 60 days after the beginning of each plan year, employers must report to CMS whether the plan's prescription drug coverage is creditable (has the same or higher actuarial value than Medicare Part D). The filing is electronic and available here.
PCORI Fee	Insurers of fully insured group health plans will file Form 720 and pay the fee. Employer sponsors of self-funded group health plans must file Form 720 with the IRS and pay the fee.**
Form 5500	Generally, applies to employer group health plans with at least 100 employee-participants at the beginning of the plan year. The Form 5500 must be filed with the DOL by the last day of the 7th month after the plan year ends. A 2½-month extension can be obtained by filing Form 5558 before the return is otherwise due.
Summary Annual Report (SAR)	The SAR is a short statement concerning the financial condition of the plan. It must be furnished to participants within 9 months after the plan year ends or 2 months after the due date for the Form 5500 filing if an extension is obtained. A SAR is generally only applicable to fully insured plans that are also subject to the Form 5500 filing requirement. If a 2½ month extension was filed for the Form 5500, the SAR due date is December 15.

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Description
The notice is required to be furnished to all participants who are Medicare Part D eligible individuals who participate in the employer's group health plan. The notice is to be furnished annually before Medicare's open enrollment period which begins on October 15. The notice discloses whether the employer's prescription drug coverage is creditable to assist individuals in deciding whether they need to enroll in Medicare Part D. If the coverage is not creditable and they do not enroll, they will pay a permanently higher premium for Medicare Part D coverage upon later enrollment.

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Annual Compliance Obligations of Group Health Plans

January & February Obligations

	Deadline	Requirement	Description
JANUARY	**1/31**	**Form W-2**	Employers that filed 250 or more W-2s in the prior year must report the cost of employer sponsored group health coverage in Box 12, using Code DD.
JANUARY	**1/31** (3/2 for automatic extension)	**Forms 1095-C and 1095-B to Employees**	Code Section 6056 and 6055 requires applicable large employers (ALEs) with fully insured and self-insured health plans to provide information about health plan coverage to their full-time employees each year, using IRS Form 1095-C. Non-ALE employers with self-insured health plans use Form 1095-B to provide this health coverage information.
FEBRUARY	**2/28** (paper) **or** **3/31** (electronically)	**Form 1094-C and 1095-Cs to IRS**	Applicable Large Employers (ALEs) (generally those with 50 or more full-time and full-time equivalent employees) must file with the IRS the 1095-Cs provided to employees along with a 1094-C transmittal form. If the employer is filing fewer than 250 1095-Cs, the employer may mail the forms to the IRS by February 28. Otherwise, the forms must be filed electronically by March 31.*

Annual Compliance Obligations of Group Health Plans

ACA Form W-2 Reporting

- Who: Employers that filed 250 or more Forms W-2 for 2019
- What: Report the total cost of employer-sponsored health coverage (including employee and employer-paid portions) in Box 12 using Code DD
- When: **January 31, 2022**

IRC Secs. 6055 and 6056 ACA Reporting

- Who: Applicable Large Employers and employers of any size that sponsored self-insured health coverage in 2020
- What: Complete Forms 1094-B/C and 1095-B/C for the 2020 calendar year
- When: Forms must be submitted to the IRS by **February 28, 2022,** if filing hard copies or by **March 31, 2022,** if filing electronically (if filing 250 or more forms, electronic filing is mandatory); distribute forms to employees and covered individuals by **March 2, 2022**

Annual Compliance Obligations of Group Health Plans

State-Level Health Coverage Reporting

- Who: Employers with covered employees residing in:
  - California
  - Massachusetts
  - New Jersey
  - Rhode Island
  - Washington, D.C.
- What: To ensure compliance with the state-enacted individual health coverage requirements, some employers are required file with the state, and provide to employees, an information return that provides details of coverage provided.
- When: The earliest deadline imposed by a state is **January 31, 2022**

Annual Compliance Obligations of Group Health Plans

Medicare Part D Disclosure to CMS

- Who: Employers that sponsor prescription drug coverage for employees
- What: Report online to CMS whether the prescription drug coverage is considered creditable or non-creditable
- When: Within 60 days following the start of the plan year (by **March 1, 2022** for calendar-year plans)

PCORI Fee

- Who: Insurance carriers and employer-sponsors of self-insured health coverage
- What: Use Form 720 to report and pay the fee, which has increased to $2.66 per covered life
- When: **July 31, 2022**

Form 5500 Filing

- Who: Employer-sponsors of group health plans that either covered at least 100 participants as of the first day of the plan year or are considered funded
- What: File Form 5500 with the U.S. Department of Labor
- When: No later than the last day of the seventh month following the end of the plan year (**July 31, 2022** for calendar-year plans)

Annual Compliance Obligations of Group Health Plans

Summary Annual Report

- Who: Employer-sponsors of insured or funded plans that were required to file a Form 5500
- What: Distribute to plan participants a short statement (called the Summary Annual Report) summarizing the financial condition of the plan
- When: Within nine months of the end of the plan year, or two months following the Form 5500 filing (**September 30, 2022** for calendar-year plans)

Medicare Part D Notice of Creditable or Non-Creditable Coverage

- Who: Employers that sponsor prescription drug coverage for employees
- What: Distribute the Medicare Part D Notice to Medicare-eligible individuals to provide information on the plan's creditable or non-creditable status
- When: No later than **October 14, 2022**

Thank You for Attending

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HR Leaders Compliance Summit
February 8-10, 2022