HR LEADERS
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HR Compliance in 2022: Preparing for the Year Ahead

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DISCLAIMER:

The information in this presentation is intended for informational purposes only and should not be construed as legal advice.

You are encouraged to consult your own legal counsel to ensure compliance with applicable laws in your specific state, municipality, or jurisdiction.

February 8-10, 2022

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AGENDA

Human Resources in 2022

- The Current Environment
- Status of Vaccine and Testing Mandates
- Wage and Hour Changes

Group Health Plan Compliance in 2022

- Transparency and Consumer Protection under the CAA
- COVID-19 Updates
- Trends in Employee Benefits
- Policy Predictions

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The Current Environment

Current Environment

Pandemic…pandemic…pandemic

- Omicron Variant
- Vaccine and Testing mandates
  - OSHA ETS
  - Federal Contractor EO
  - CMS Rule for Health Care Workers
- At-home Testing Insurance Coverage
- Wage and Hour Issues
- EEOC AI Initiative

Employers remain on a teeter totter

Status of Vaccine and Testing Mandates

OSHA Emergency Temporary Standard Regarding Mandatory Vaccination/Testing

- The Emergency Temporary Standard (ETS) developed by the Occupational Safety and Health Administration (OSHA) required all covered employers with 100 or more employees to either mandate their workforce receive the vaccination against COVID-19 or test them weekly to ensure they are not infected.
- ETS published on November 5, 2021…it was immediately effective
- Supposed to be enforced beginning on December 6, 2021
- 5th Circuit blocked enforcement on November 6th by issuing a temporary "stay"
- On November 12th, the 5th Circuit extended the stay

OSHA Emergency Temporary Standard Regarding Mandatory Vaccination/Testing

- The 5th Circuit had an interesting take on the ETS
- The mandate needed to be "delicately exercised" but that it was drafted as a "one-size fits all sledgehammer" and not a "delicately handled scalpel"
- Overinclusive and underinclusive at the same time
- Overinclusive because not every workplace poses a "grave danger" as some are more dangerous than others
- Underinclusive because if this is a true emergency then the same risks apply for a workplace of 99 employees as 100
- Also questioned why OSHA found an emergency now but not earlier in the pandemic

OSHA Emergency Temporary Standard Regarding Mandatory Vaccination/Testing

- On November 15th, the Judicial Panel of Multidistrict Litigation had a ping pong ball lottery to decide which Circuit would hear the appeal
- The conservative 6th Circuit won the lottery (Ohio, Michigan, Tennessee, and Kentucky)
- Getting to the lottery involved some strategy on both the conservative and liberal sides.
- Most groups filed federal actions stating that the ETS was an overreach, but some said it didn't go far enough just to get that circuit in the lottery
- 6th Circuit is one of the most conservative in the country right now
- It contains 20 judges appointed by Republicans and 6 appointed by Democrats
- On December 18, 2021, the Sixth Circuit surprisingly lifted the stay on the ETS and the case was immediately appealed to the Supreme Court
- The Supreme Court heard oral arguments on January 7, 2022 to determine if the stay should be reinstituted pending full review of the merits of the litigation

OSHA Emergency Temporary Standard Regarding Mandatory Vaccination/Testing

- On January 13, 2022, the Supreme Court issued a 6-3 opinion reinstituting the stay for the ETS
- The Supreme Court did not rule on the validity of the OSHA ETS, as the scope of their review was to determine whether the previous temporary injunction of the ETS had been appropriately put into place
- As the Court explained, under the law, OSHA is empowered to "set workplace safety standards, not broad public health measures"
- Continuing, the majority explained that "although COVID-19 is a risk that occurs in many workplaces, it is not an occupational hazard in most"
- Thus, the majority held, allowing OSHA to regulate broadly "the hazards of daily living" would expand OSHA's authority beyond the bounds Congress set for it

OSHA Emergency Temporary Standard Regarding Mandatory Vaccination/Testing

- On January 25, 2022, OSHA withdrew its ETS in response to the Supreme Court decision and effectively ended the litigation
- Although OSHA hoped the ETS would be effectuated, it also acted as a proposal for a permanent standard, which is separate from the litigation and requires the agency to undergo a formal rulemaking process with a notice-and-comment period
- Although the rule is now dead as an ETS, it is still alive as a proposed rule: "zombie rule"
- Due to the Supreme Court ruling, OSHA can't adopt the language of the ETS for its permanent standard so it will likely narrow the scope
- Likely approach is to focus on high hazard industries (factories, assembly lines, etc.)
- Comments were open until 1/19 and received 121,000, the most ever for an OSHA proposed rule

OSHA Emergency Temporary Standard Regarding Mandatory Vaccination/Testing

- **What should employers do now?**
- OSHA may reopen the record to receive more comments regarding changes they intend to make to the original language of the ETS
- They don’t want to create a rule that will again be rejected in litigation
- **It is likely that employers will see a regular COVID-19 standard proposed at some point this year**
- Although the ETS is dead, employers should still pay attention to continuing obligations
- OSHA’s general duty clause requires employers to provide a work environment that is "free from recognized hazards that are causing or are likely to cause death or serious physical harm”
- OSHA recommends that employers encourage workers to get vaccinated; provide paid time off for vaccination; ensure rooms are properly ventilated; set rules for masking, physically distancing and practicing good hygiene; and have protocols in place for employees to follow if they test positive for COVID-19

Federal Contractor and Subcontractor Vaccine Mandate

- Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors signed on September 9, 2021.
- Initially, the deadline for the vaccine mandate was December 8, 2021, but that deadline was extended to January 18, 2022.
- This means that covered contractors needed to receive their Johnson & Johnson vaccine or the second dose of a Pfizer or Moderna vaccine by January 4 to be fully vaccinated by January 18.
- On November 30, 2021, the U.S. District Court for the Eastern District of Kentucky issued an order granting a preliminary injunction to block the enforcement of the vaccine mandate for federal contractors and subcontractors in all covered contracts in Kentucky, Ohio, and Tennessee.
- On December 7, 2021, a federal district court in Georgia issued a preliminary injunction on a nationwide basis in Georgia v. Biden.
- On December 17th, a three-judge panel of the Eleventh Circuit denied the federal government's request for a stay of the district court's injunction finding that the government had "not established one of 'the most critical' factors—that it will be irreparably injured absent a stay."

Federal Contractor and Subcontractor Vaccine Mandate

- The original order had four key requirements:
  - A vaccine mandate requiring full vaccination for employees of covered federal contractors with limited exceptions for those legally entitled to an accommodation (prior COVID-19 infection or antibody tests are not accepted as substitutes)
  - Covered contractors must verify an employee's vaccination status by obtaining proof and cannot document an employee's vaccination status by way of self-attestation.
  - Mask and physical distancing requirements at covered contractor worksites (including for employees, visitors and others)
  - A requirement that contractors designate a person or persons to coordinate COVID-19 workplace safety efforts at their workplaces (risk management coordinator)
- No testing option in lieu of vaccinations

Federal Contractor and Subcontractor Vaccine Mandate

- **What should covered employers do now?**
- Despite the nationwide injunction, remain prepared to comply with the mandate in the event the Eleventh Circuit upholds the mandate
- Covered contractors should contact legal counsel and consider developing policies to collect employee vaccine information, but may delay requiring employee compliance with the mandate until the Eleventh Circuit makes a decision (and monitor any further appeals possibly to the Supreme Court)
- Covered employers should continue to keep their employees informed on the status of the mandate
- For those covered contractors who have already had the federal contractor mandate clause added to existing agreements, make sure and communicate with your contracting officer regarding the injunction
- Covered federal contractors should also be aware of any current or future requirements or restrictions pertaining to vaccines, masking, or other safety measures, which may be imposed by state or local law in all of their worksite locations

COVID-19 vaccine mandate for in-person employees of Medicare- and Medicaid-certified healthcare providers and suppliers

- The mandate applied to several Medicare- and Medicaid-certified providers and suppliers, including hospitals, long-term care facilities, nursing homes, and others.

- The mandate contemplated implementation in two phases.
    - For Phase 1, staff at all healthcare facilities that were covered by the regulation must have received, at a minimum, the first dose of a two-dose vaccine or a single-dose COVID-19 vaccine as well as putting policies and procedures in place.
    - For Phase 2, staff must be fully vaccinated.
    - For both phases, exceptions are permitted for those who are granted religious or medical exemptions from the COVID-19 vaccine, as well as for staff members for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC.

- No testing option in lieu of vaccination is permitted.

COVID-19 vaccine mandate for in-person employees of Medicare- and Medicaid-certified healthcare providers and suppliers

- The Centers for Medicare & Medicaid Services (CMS) published the interim final rule implementing its vaccine mandate on November 5, 2021.
- There were several different injunctions issued around the nation in different jurisdictions to stay the enforcement of the initial rule.
- The Supreme Court heard oral arguments on January 7, 2022 to assess the validity of the existing injunctions
- On January 13, 2022, the Supreme Court, in a 5-4 decision, lifted all lower court injunctions that had blocked enforcement in 25 states.
- Unlike the OSHA ETS, which was not enforced, the Supreme Court concluded that CMS had acted squarely within the authority delegated to it when it published the CMS Rule.
- "After all," the Court found, "ensuring that providers take steps to avoid transmitting a dangerous virus to their patients is consistent with the fundamental principle of the medical profession: 'first, do no harm.'"

COVID-19 vaccine mandate for in-person employees of Medicare- and Medicaid-certified healthcare providers and suppliers

- CMS Guidance released on various dates created differing rules for groups of states

December 28th guidance applies to: California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, North Carolina, Nevada, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, Washington, and Wisconsin (Group 1)(Never enjoined)
January 14th guidance applies to: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Utah, West Virginia, and Wyoming (Group 2)(Injunction lifted)
January 20th guidance applies to: Texas (Injunction lifted)

COVID-19 vaccine mandate for in-person employees of Medicare- and Medicaid-certified healthcare providers and suppliers

- Various CMS Guidance released on various dates created differing rules for groups of states

	Phase 1	Phase 2	Full Enforcement
Group 1 Deadline	January 27	February 28	March 28
Group 2 Deadline	February 14	March 15	April 14
Texas Deadline	February 27	March 21	April 20

Executive Order Requiring Carriers to Pay for At-Home COVID Tests

- Guidance was issued on January 10, 2022 by the Departments of Labor, Health and Human Services, and the Treasury formally requiring employer health plans to cover OTC COVID-19 diagnostic tests for their plan participants
- The requirement of coverage went into effect on January 15, 2022
- Health plans and insurers may set limits on the number and frequency of covered OTC COVID-19 tests but must cover at least 8 tests per month or 30-day period
- There is no requirement that any health care provider order or be involved with the OTC COVID-19 test in order to get reimbursed although there is a requirement that the tests be used for diagnostic purposes
- Plans are not required to provide coverage of testing (including an at-home over-the-counter COVID-19 test) that is for employment purposes
- Would have been a much bigger issue had the OSHA ETS been upheld due to scarcity of tests

Wage and Hour Changes

Potential Costs

Since 2004 the number of **FLSA cases** filed in Federal Court has **more than doubled**

Plaintiffs can get **back wages and overtime** going back **up to 3 years** under Federal Law (longer under some state laws)

Liquidated **damages**

Reasonable **attorney's fees and costs**

Tax liability

Personal liability

DOL Final Rule for Tipped Employees

- On October 28, 2021, the DOL published the final "dual jobs" rule which resurrected the "80/20 Rule" governing how to pay tipped employees under the FLSA
- Final rule became effective on December 28, 2021
- The focus of the rule is to assess when an employer must pay an employee full minimum wage versus when an employer can pay less than minimum wage and utilize the tip credit to meet their minimum wage compliance obligations
- In an opinion letter in November 2018, the DOL basically removed the quantitative standards and simply said that the tip credit could be used if tasks were performed contemporaneously with direct customer service duties or for a reasonable amount of time immediately before or after

DOL Final Rule for Tipped Employees

- In December 2020, the DOL issued a final rule adopting the language in the November opinion letter
- In February 2021 and April 2021, the DOL delayed the effective date of the December final rule and on June 23, 2021, the DOL issued a notice of proposed rulemaking and then issued the final rule on October 28, 2021
- Politics at play

DOL Final Rule for Tipped Employees

- October 2021 final rule created a functional test to assess tip credit
- Tipped employee's work duties must be divided into 3 categories:
  - Tip-producing work
  - Directly supporting work
  - Work that is not part of a tipped occupation

DOL Final Rule for Tipped Employees

- **Tip-Producing Work definition**
- Must provide "service to customers for which tipped employees receive tips"
- Bartender example duties include:
  - Making and serving drinks
  - Talking to customers at the bar
  - Serving food to customers at the bar
  - Changing the tv channel for a customer
- Directly supporting duties can be elevated to tip producing
- If a bartender goes to retrieve a beer from the storeroom due to a customer request it is tip producing but if they just go to the storeroom to restock beer generally it is directly supporting

DOL Final Rule for Tipped Employees

- **Directly Supporting Work definition**
- Must be "performed in preparation of or to otherwise assist tip-producing customer service work"
- Directly supporting duties may be paid at a tip credit rate if the work is not performed for a "substantial amount of time"
- A substantial amount of time is defined as either:
  - More than 30 continuous minutes; or
  - More than 20% of the hours in the workweek for which the employer has taken a tip credit
- For example, if a tipped employee worked 40 hours in a week, but 5 of those hours were paid at full minimum wage for whatever reason, then the 20% calculation applies only to the 35 hours of tip credit. The employee could do up to 7 hours of "directly supporting duties and still use the tip credit"

DOL Final Rule for Tipped Employees

- **Bartender example duties include:**
  - Slicing and pitting fruit for drinks
  - Wiping down bar
  - Wiping down tables in bar area
  - Cleaning bar glasses
  - Arranging bottles behind bar
  - Cleaning ice coolers and bar mats
  - Making drink mixes
  - Filling drink mix dispensers

DOL Final Rule for Tipped Employees

- **Non-tip producing or direct supporting work definition**
- Any duties that are neither tip-producing nor directly supporting
- Any time spent in this category **must** be compensated at the minimum wage level
- No de minimis exception
- If a tipped employee spends 30 seconds tidying up a restroom, the employee is entitled to full minimum wage for that 30 seconds
- Bartender example duties include:
  - Cleaning dining room or bathrooms

DOL Final Rule for Tipped Employees

- **Miscellaneous aspects of the final rule**
- If a tipped employee is multitasking, such as a bartender talking to a customer while organizing the bar, the tip-producing activity "trumps" so that the time is considered tip-producing
- Tracking and recording directly supporting work is difficult especially if an employee is quickly pivoting among various work duties; be prepared to have a way to track
- The DOL believes that employers can assign directly supporting work only in blocks of scheduled time and thus ensure that such work is not performed for a substantial amount of time
- Try to avoid tipped employees doing any work in the third category of work that is not part of a tipped occupation because any time in this category must be paid at minimum wage and will be difficult to track

DOL Rescission of New Independent Contractor Rule (May 5, 2021)

- Would have made it easier for businesses to classify workers as independent contractors rather than employees.
- The rule would have primarily focused on who controls the work and whether the worker has the opportunity for profit and loss.
- For now, the DOL will continue to evaluate employment relationships under an established multifactor test, though President Biden has advocated for a more-stringent standard.
- Wage and Hour Director nominee David Weil has called for a stricter test that would render most gig workers employees although that is not likely to happen any time soon.

EO Raising Minimum Wage to $15 for Federal Contractors (April 27, 2021)

- The federal minimum wage is currently $7.25 an hour and hasn't been raised since 2009.
- President Biden will likely push for a $15 federal minimum wage for all workers but will require Congressional action.
- On April 27, 2021, Biden signed an executive order to implement a $15 minimum wage for federal contractors on January 30th.

DOL Possibly Raising the Exempt Salary Threshold

- The DOL can engage in rulemaking to raise the exempt salary threshold.
- Under the FLSA, workers must be paid 1 1/2 times their regular rate of pay for all hours worked beyond 40 in a workweek unless they fall under an exemption.
- The most used exemptions are the administrative, executive and professional, collectively called white-collar exemptions.
- To qualify for these exemptions, employees must perform certain duties, be paid on a salary basis and meet a minimum salary threshold.
- The prior administration increased the minimum salary level from $455 a week ($23,660 annualized) to $684 a week ($35,568 annualized).
- During the Obama administration, the DOL attempted to increase the threshold to $913 a week ($47,476 annualized), but that increase was blocked by a federal judge.
- On the DOL's long term agenda but should be on employer's radars

DOL Enforcement

- The DOL actively conducted investigations under the Trump administration but didn't push as hard for liquidated (or double) damages when resolving matters.
- Under the Biden administration, employers should expect the DOL to again push for liquidated damages.
- The DOL also may hire more investigators. Proposed budget sent to Congress at the end of May included a massive increase in funds for DOL enforcement.
- Around $30mm and 175 new FTEs

EEOC Artificial Intelligence Initiative (October 28, 2021)

- The initiative will examine more closely how technology is fundamentally changing the way employment decisions are made.
- Chair of the EEOC, Charlotte Burrows recently stated that "Artificial intelligence and algorithmic decision-making tools have great potential to improve our lives, including in the area of employment," and "at the same time, the EEOC is keenly aware that these tools may mask and perpetuate bias or create new discriminatory barriers to jobs. We must work to ensure that these new technologies do not become a high-tech pathway to discrimination."
- It aims to guide applicants, employees, employers, and technology vendors in ensuring that these technologies are used fairly and consistently with federal equal employment opportunity laws.
- This is an important question to ask of any potential vendors that your organization is looking to utilize for AI recruitment

Group Health Plan Compliance in 2022

Transparency and Consumer Protection under the CAA

The Consolidated Appropriations Act

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 (The No Surprises Act)
- Pricing Transparency
- Prescription Drug Reporting
- Mental Health Parity Nonquantitative Treatment Limitations (NQTL) Comparative Analysis

The No Surprises Act

Protects 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). This is generally referred to as "surprise billing" or "balance billing."

> Jane 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 (insured and self-insured)
- Health insurance carriers (for both group and individual coverage)
- Providers
- Some service facilities

The No Surprises Act

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 and 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)
- **Air Ambulance**
  - Services: In and out-of-network air ambulance services, if covered under the plan
  - Member Liability: In-network cost-share only (e.g., copay, deductible, coinsurance)
- **Non-Emergency Care**
  - Services: Certain out-of-network non-emergency services (Jane's example)
  - Location: In-network facilities
  - Member Liability: In-network cost-share only unless member receives advanced notice of balance billing and provides written consent

The No Surprises Act

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)

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.

The No Surprises Act

Action Items:

- For **fully-insured health plans**, confirm 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 SPD, if necessary
  - Collect the updated policy, certificate of coverage (also referred to as a member booklet or plan summary), and other plan documents which describe the services included in the Act
- Post the Balance Billing Protections Notice

No Surprises: Understand Your Rights in the "No Surprises Act"

- "No Surprises Act" took effect Jan 1, 2022
- Simple Definition: A surprise medical bill is an unexpected balance bill
  - Balance bill is a portion of bill not covered by insurance
  - Protections:
    1. Services received by an out-of-pocket provider at in-network facility
    2. Services received by in-network facility by out-of-network provider
    3. Emergency rooms out-of-network air ambulance providers
       - Does not protect from OON ground ambulance providers
    4. ER facility/ER physicians CANNOT ask for a patient wavier
       - Includes Asst. Surgeon, Anesthesiologist, Radiologists, Hospitalists, Intensivists
  - State Laws will supplement the No Surprise Act
  - ERISA Plans bound by regulations: "For anyone with insurance"

No Surprises:
Understand your rights against surprise medical bills

healthlock

The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers, and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

Starting in 2022, there are new protections that prevent surprise medical bills. If you have private health insurance, these new protections ban the most common types of surprise bills. If you're uninsured or you decide not to use your health insurance for a service, under these protections, you can often get a good faith estimate of the cost of your care up front, before your visit. If you disagree with your bill, you may be able to dispute the charges. Here's what you need to know about your new rights.

What are surprise medical bills?

- Before the No Surprises Act, if you had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, your health plan may not have covered the entire out-of-network cost. This could have left you with higher costs than if you got care from an in-network provider or facility. In addition to any out-of-network cost sharing you might have owed, the out-of-network provider or facility could bill you for the difference between the billed charge and the amount your health plan paid, unless banned by state law. This is called "balance billing." An unexpected balance bill from an out-of-network provider is also called a surprise medical bill. People with Medicare and Medicaid already enjoy these protections and are not at risk for surprise billing.

What are the new protections if I have health insurance?

If you get health coverage through your employer, a Health Insurance Marketplace®, [1] or an individual health insurance plan you purchase directly from an insurance company, these new rules will:

- Ban surprise bills for most emergency services, even if you get them out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network facility.
- Require that health care providers and facilities give you an easy-to-understand notice explaining the applicable billing protections, who to contact if you have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections (i.e., you must receive notice of and consent to being balance billed by an out-of-network provider).

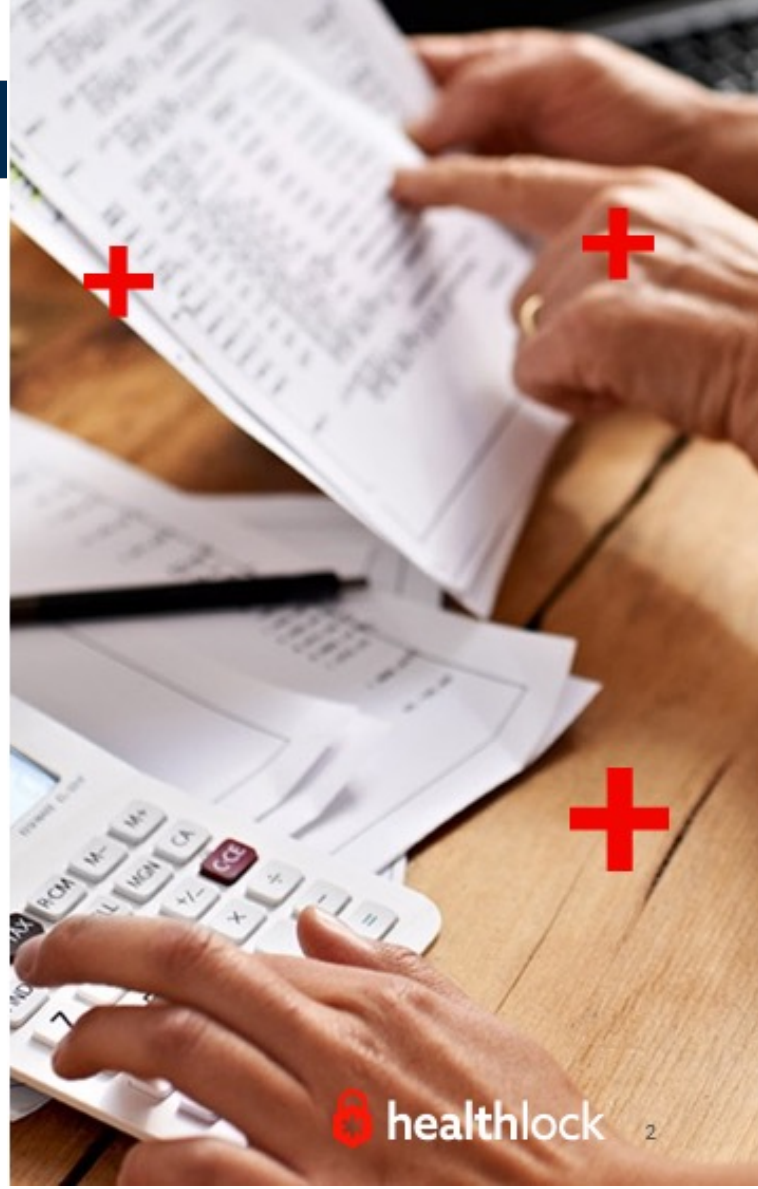
[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

No Surprises: Understand Your Rights in the "No Surprises Act"

- Independent dispute resolution for insured and uninsured
  - 120 days from billing date to file claim
  - Over $400 of good faith estimate for uninsured
  - Medical/Medicaid already have protections; not at risk

- Billing Overcharges
  - $240 billion lost
  - 200M denied insurance claims – an only .2% appealed the denials
  - 66% of bankruptcies due to medical bills
  - 52% of credit issues

- Privacy and Fraud
  - Medical record/group # is 10-40 times more valuable than social security number
  - 41,000,000 privacy breaches in 2020 – 3x increase since 2018
  - $82 billion lost from fraud, cyber and privacy breaches



[1]HIPAA Journal [2]Federal Trade Commission [3]CyberSecurity [4]Los Angeles Times [5]AARP [6]KFF.org [7]Medical Billing Advocates of America

HealthLock + Acrisure Protection

- How about: No billing surprises. Period
  - HealthLock's patent-pending software sync's with insurance provider
  - Fully insured and self-funded (i.e Anthem/Cigna/UHC and TPA's)
  - Automatically downloads, organizes, and monitors your healthcare transactions
  - Verify every healthcare transaction – self-learning AI uncovers fraud & overcharges
  - ROI: $135,000,000 and counting

- Privacy, Fraud and Balance Billing Protection
  - Alerts to privacy breaches, HIPPA violations and malpractice
  - Fixes balance billing, MedID theft and includes comprehensive ID theft protection

- Free Download – HealthLock.com/Acrisure
  - Find lost money – Audits past two years of medical transactions
  - HealthLock Essentials™ - Free privacy protection and bill verification
  - HealthLock.com/Acrisure – Code: NoMoreSurprises

Pricing Transparency

Applies to: Group health plans (insured and self-insured) and health insurance carriers in the group and individual markets

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**
- **Price Comparison Tool**
  - Guidance (phone) or tool (website) providing price comparison of cost-sharing that a member would be responsible to pay for a specific item or service
  - 500 most common "shoppable" expenses (effective **January 1, 2023**)
  - All covered expenses (effective **January 1, 2024**)

Pricing Transparency

Key Provisions (cont'd)

- **Advanced Explanation of Benefits (EOB) for Scheduled Services**
  - Must be requested
  - Must be provided within 1 business day after receipt of the notification from the provider unless the service is scheduled at least 10 days in advance, in which case the plan has 3 business days to provide it
  - Must include (not exhaustive list)
    - Provider or facility network status
    - Good faith estimate of the cost of service, the amount the plan will pay, any cost-sharing, and the amount the member has incurred to-date toward meeting their deductible and out-of-pocket maximums
    - A disclaimer if the service is subject to prior authorization, concurrent review, or other medical management requirements
  - Effective for plan years beginning on or after **January 1, 2022** (note: delayed enforcement until regulations and other guidance are issued)

Pricing Transparency

Key Provisions (cont'd)

- **Continuity of Care**
  - "Continuing Care Patient" is an individual receiving certain care from an in-network provider or facility, such as:
    - Treatment for a serious and complex condition (both inpatient and out-patient care)
    - Undergoing a course of inpatient 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 noncontinuing care patient status (whichever is earlier)
  - Effective for plan years beginning on or after **January 1, 2022**

Pricing Transparency

Action Items

- For **fully-insured health plans**, confirm that these provisions will be handled by the carrier
- For **self-insured health plans**, work with TPAs, rental network providers, and others for assistance implementing these new rules
  - Creation of and maintenance of the cost-comparison tool
  - Provision of Advanced EOBs upon request
  - Distribution of updated SPDs and other plan documents or summaries, as well as I.D. cards

Prescription Drug Reporting

Applies to: Group health plans (insured and self-insured) and health insurance carriers

Key Provisions: Requires plans and carriers to report to the DOL, IRS, and HHS certain information regarding costs associated with prescription drug benefits.

- First report was due December 27, 2021, with annual reporting thereafter due June 1
- Reports must include:
  - The number of covered participants and beneficiaries
  - The state the plan is offered in
  - The top 50
    - Dispensed brand prescription drugs and the number of claims
    - Most expensive prescription drugs by annual spend
    - Prescription drugs with the highest increase in plan expenditures
  - Average monthly premiums paid by employer and employees
  - Rebates, fees, and other remuneration paid by manufacturers
- HHS will publicly post de-identified aggregate reports on their website on drug pricing trends and the contribution of drug costs to premium increases

Prescription Drug Reporting

Effective Date: **December 27, 2021** (note: enforcement is delayed until December 27, 2022, at such time submitted reports must include 2020 and 2021)

Action Items

- For **fully-insured health plans**, confirm that the carrier is prepared to complete the necessary reporting; if the medical plan is insured but the prescription drug coverage is carved out, these requirements will fall upon the employer-sponsor
- For **self-insured health plans**, discuss preparations for these reporting requirements with TPAs and PBMs
  - Where the TPA or PBM will complete the report on the employer's behalf, ensure service and fee agreements are updated to reflect this delegation of responsibility
  - Where the TPA or PBM will not complete the reporting, ensure that access to necessary data will be provided and understand the process and timeline for completing the reports

Mental Health Parity NQTLs 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
- 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

Mental Health Parity NQTLs Comparative Analysis

Key Provisions (cont'd)

- 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, which must be provided to the DOL, IRS or HHS upon request

Effective Date: February 10, 2021

Action Items

- For **fully-insured health plans**, the NQTL comparative analysis requirement falls upon the health insurer
- For **self-insured health plans**, the analysis requirement falls upon the employer-sponsor
  - 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
  - Going forward, completion of the analysis should be detailed in any TPA/ASO contract for services

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, 2022)
- **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

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

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

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

- **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.


Trends in Employee Benefits

On-Site COVID-19 Testing Programs

In an effort to create a safer work environment and provide employees greater access to COVID-19 testing, employers may find value in on-site testing programs offered by vendors that may include complementary services.

Compliance Considerations

- **HIPAA**
  - To release test results directly to the employer, the testing provider must secure proper authorization from the employee
  - Authorization can be avoided if results are released to the employee who then submits them to the employer
- **ACA**
  - So long as the program is limited to diagnostic testing, it will qualify as an excepted benefit EAP and may therefore be offered to employees regardless of their enrollment in the medical plan
  - Programs that provide additional benefits are unlikely to be considered an excepted benefit EAP; may be able to rely on temporary relief for telemedicine benefits while the public health emergency is ongoing
- **ERISA and COBRA**
  - Regardless of whether the program provides significant benefits in the nature of medical care, group health plan status under ERISA and COBRA will likely apply to employer-provided testing

Mental Health Benefits

As a result of the ongoing COVID-19 public health emergency, mental health benefits have garnered increasing interest. Typically, the programs are offered on a stand-alone basis through a separate vendor or contract, and provide services through a virtual format.

Compliance Considerations

- **HSA Eligibility**
  - Programs that do not provide significant benefits in the nature of medical care will not jeopardize HSA eligibility (e.g., programs limited to virtual therapy with a cap on the number of available visits in a year)
  - Programs that provide more significant care will not meet this exception; temporary COVID-19 relief expires for plan years beginning on or after January 1, 2022
- **ACA**
  - So long as the program does not provide significant benefits in the nature of medical care and requires no employee cost-sharing or contribution, the program will likely qualify as an excepted benefit EAP
  - May therefore be offered to employees regardless of their enrollment in the medical plan
- **ERISA and COBRA**
  - Regardless of whether the program provides significant benefits in the nature of medical care, group health plan status under ERISA and COBRA will apply

Infertility HRAs

An increasingly popular solution for employers who wish to offer more robust and cost-effective infertility benefits is to set up a health reimbursement arrangement (HRA) to provide tax-free reimbursement of medical expenses related to infertility treatment.

Compliance Considerations

- **Qualified Medical Expenses**
  - An HRA can provide tax-free reimbursements for only qualified medical expenses; this does not include benefits such as adoption assistance or surrogacy
- **HSA Eligibility**
  - To preserve HSA eligibility, must be structured as a post-deductible HRA, which requires participants to first satisfy the minimum statutory deductible before eligible medical expenses can be reimbursed
- **ACA**
  - To comply with the market reforms, an HRA must be integrated with employer-sponsored medical coverage, which requires participation to be limited to employees who are also enrolled in the employer's medical plan(s) or to employees who demonstrate enrollment in another employer's medical plan
- **ERISA and COBRA**
  - HRAs, including infertility HRAs, are considered group health plans subject to ERISA (which requires inclusion in the SPD, annual 5500 filings, etc.) and COBRA

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 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 would be decreased and fixed at 8.5%
- **Commonsense Reporting Act** (HR 5318)
  - 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

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

- **The Personal Health Investment Today Act** (HR 1679)
  - Would recognize sports and fitness expenses as qualified eligible expenses under pre-tax savings arrangements, including HSAs and Health FSAs

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 **out-of-pocket 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**

February 8-10, 2022

HR LEADERS
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