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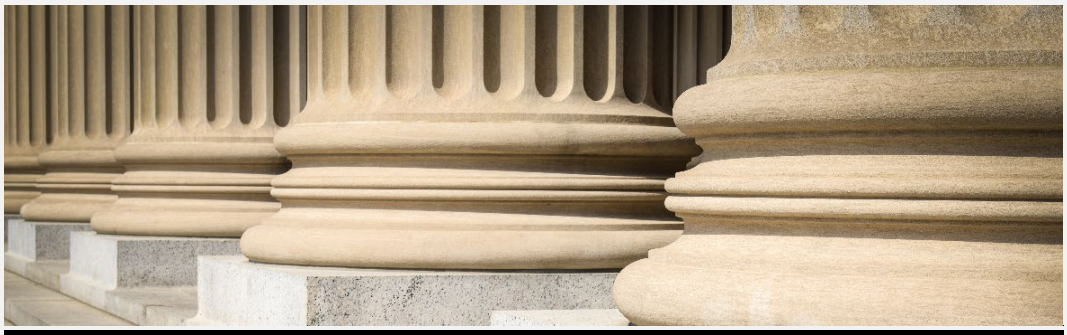

Rewards Policy Insider
2021-17

In this Issue:

Agencies Delay Enforcement of Certain New Group Health Plan Requirements

Group health plans are facing significant compliance challenges for plan years beginning on or after January 1, 2022 due to a series of new regulatory and legislative requirements that are scheduled to take effect. The Departments of Health and Human Services, Labor, and Treasury ("Departments"), which share enforcement jurisdiction over these provisions, on August 20 issued a set of Frequently Asked Questions ("FAQs") that provide some much-needed relief from some of the relevant enforcement deadlines as they work to provide necessary guidance.

Background

In addition to the new "surprise billing" requirements, which are on track to take effect for plan years beginning on or after January 1, 2022, the Consolidated Appropriations Act (CAA), 2021 included a number of other new requirements designed to make certain aspects of group health plans more transparent to participants and others.

Some of the new requirements substantially overlap with requirements included in the Transparency in Coverage (TinC) Final Regulations issued late last year. Other new CAA requirements will require regulatory guidance to be fully implemented, and the agencies need more time to get that guidance out.

Price Comparison Tools

Both the CAA and the TinC Final Rule include provisions requiring group health plans to provide tools that participants can use to compare their expected out-of-pocket costs for receiving the same services from different providers and/or facilities.

In brief, the relevant CAA provisions require group health plans to offer price comparison guidance via telephone, and to make a "price comparison tool" available on plan websites. *This requirement is effective for plan years beginning on or after January 1, 2022.*

The TinC Final Rule, by comparison, requires group health plans to make price comparison information available through an internet-based self-service tool and in paper form, upon request. *This requirement is scheduled to take effect for plan years beginning on or after January 1, 2023 for 500 items and services identified in the preamble to the TinC Final Rule, and for plan years beginning on or after January 1, 2024 for all other covered items and services.*

As a result, according to the FAQs:

- The Departments plan to issue proposed rules to require that the same pricing information that is available through the online tool or on paper, pursuant to the TinC Final Rule, also be provided via telephone upon request.
- Because plans and health insurance issuers have already started working towards the TinC Final Rule effective date (i.e., plan years beginning on or after January 1, 2023 for the initial 500 items and services), *the Departments will defer enforcement of the related CAA provisions until plan years beginning on or after January 1, 2023.*

Machine Readable Files

Another significant component of the TinC Final Rule is the requirement for group health plans to publicly disclose – in three separate machine-readable files – information about in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs. *These requirements were originally scheduled to apply to plan years beginning on or after January 1, 2022.*

The CAA also includes provisions with new prescription drug reporting requirements that at least partially overlap with the information to be included in the machine-readable file relating to prescription drugs. As a result, the FAQs state the Departments will indefinitely defer enforcement of the requirement to publish the prescription drug machine-readable file.

Additionally, the Departments are deferring enforcement of the in-network and out-of-network machine readable file requirements until July 1, 2022.

Finally, the Departments are deferring enforcement of the CAA provisions relating to reporting on prescription drug benefit costs for reporting otherwise due on December 27, 2021 and June 1, 2022 until further guidance is issued. However, the Departments are "strongly encouraging" plans and issuers to be ready to begin reporting by December 27, 2022.

Other CAA Requirements

For the time being, the Departments will be applying a good faith, reasonable standard for compliance with the following CAA provisions:

- Plans must include deductibles and out-of-pocket maximums on plan identification cards;
- When there are changes to a provider's network status with respect to a plan, the plan must continue to treat the provider as in-network for a limited period of time in certain circumstances; and
- If plans do not keep their provider directories up-to-date, they may be required to treat an out-of-network provider as in-network if a participant relied on inaccurate information in the provider directory.

The CAA also includes a new requirement for group health plans to provide cost estimates to participants in advance in certain circumstances. However, the plan's obligation is triggered by a notice from the provider, and the Departments are delaying enforcement of the provider requirement. As such, the Departments are not enforcing the relevant group health plan requirement until implementing guidance is issued.

The FAQs are available here.

Employer Incentives for Employees to be Vaccinated May Implicate the HIPAA Nondiscrimination Rules

Some employers are imposing health insurance premium surcharges against employees who participate in their group health plans but have not yet received the COVID-19 vaccine. While this can be an effective way to encourage plan participants to be vaccinated, employers should be mindful of the HIPAA nondiscrimination rules when implementing such programs.

What are the HIPAA Nondiscrimination Rules?

In general, the HIPAA nondiscrimination rules prohibit group health plans from discriminating against an individual with respect to eligibility or premium contributions based on a health status factor. Simply put, group health plans cannot deny eligibility to employees who are sick or have other health problems or issues, and they cannot make them pay a larger premium contribution either.

There is an exception to this general rule, however, for certain wellness programs. For example, the HIPAA nondiscrimination rules generally preclude group health plans from giving a premium discount to non-smokers. The reason is that nicotine addiction is a health status or condition. Under the wellness program exception, group health plans can provide this discount to non-smokers, but only if certain specific requirements are satisfied. These requirements include:

- The discount must not exceed certain specific limits; and
- Smokers who cannot quit due to their nicotine addiction must be given a "reasonable alternative standard" to earn the discount.

What does this have to do with COVID Vaccines?

Some people may not be able to be vaccinated due to a health condition, such as allergies. So, if employers charge a higher premium to those who are not vaccinated, they will need to follow the wellness plan exception in order to avoid potential problems with the HIPAA nondiscrimination rules.

In terms of the size of the premium surcharge, it generally could not exceed 30% of the total cost of self-only coverage.

The reasonable alternative standard for those who cannot be vaccinated is not so easily quantified and may vary from individual to individual based on the specific situation. It could be something as simple as requiring an employee to watch a video on minimizing the risk of transmitting COVID-19 to others.

Other Considerations

Of course, other federal, state, and local laws may come into play as well. On the federal level, the Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, and Title VII of the Civil Rights Act, among others, may need to be considered.

Employers considering vaccine incentives or mandates should consult with employment and benefits counsel when designing programs to avoid inadvertent violations of these and other relevant laws.

BREAKING NEWS

On September 9, President Biden announced that the Department of Labor's Occupational Health and Safety Administration (OSHA) will be issuing an emergency temporary standard to require employers with 100 or more employees to either be vaccinated or tested weekly for COVID. Federal contractors and certain health care providers will be subjected to new vaccine mandates without testing options. Details are not yet available, and there are many open questions including how this new mandate will interact with other Federal employment laws. More information will be provided in Rewards Policy Insider 2021-18.

GAO Issues Report on 401(k) Fees, Including Recommendations for Regulatory Changes

The Government Accountability Office (GAO) has issued a new report on 401(k) plan fees, indicating that participants do not understand the fees they are being charged. The report also recommends specific steps the Department of Labor (DOL) can take to address the perceived problems.

According to the GAO report, about 40% of 401(k) plan participants do not fully understand the fee information that current DOL regulations require plans to disclose. The report also found that 41% of participants mistakenly believe they do not pay any fees at all.

To address these and other concerns, the GAO report makes the following five specific recommendations to the DOL:

- Require fee disclosures to use a consistent term for asset-based investment fees (e.g., gross expense ratio);
- Require that quarterly participant statements disclose the actual cost of asset-based investment fees paid;
- Take steps to provide participants important information concerning the cumulative effect of fees on savings over time (e.g., ensuring disclosures cite a working, specific DOL web address for where such information is shown and requiring that fee disclosures include the agency's graphic illustration on the cumulative effect of fees);
- Require that participant fee disclosures include fee benchmarks for in-plan investment options; and
- Require that participant fee disclosures for participant-directed individual retirement accounts include ticker information for in-plan investment options, when available.

Additional information about the GAO report, including links to download the full report, is available here.

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