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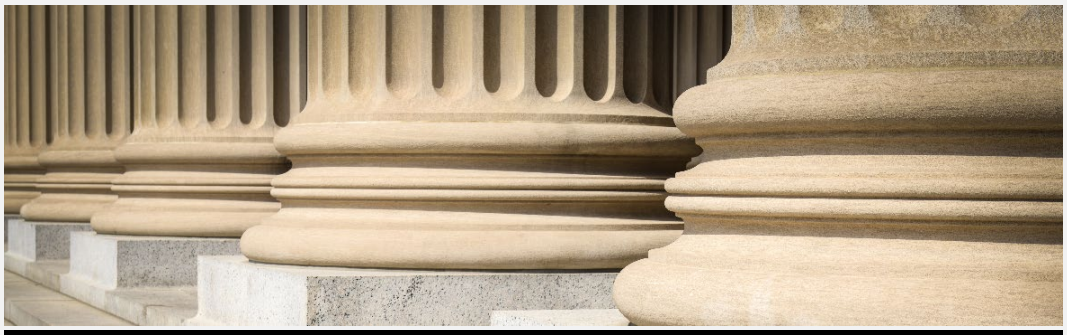
United States | Human Capital | 12 February 2021



Rewards Policy Insider
2021-2

In this Issue:

Tri-Agencies Issue Transparency in Coverage Rules for Group Health Plans

For plan years beginning on or after January 1, 2022, group health plans and issuers of group coverage will be required to make publicly available three machine-readable files that include detailed, plan-specific pricing information such as negotiated rates with network providers and pharmacies for covered services and prescription drugs. Over the following two years, group health plans also will need to offer an internet-based self-service tool that participants and beneficiaries can use to get real-time, personalized out-of-pocket cost estimates for health care items and services from network providers.

The Departments of Health and Human Services (HHS), Labor, and Treasury (the "Tri-Agencies") issued the "Transparency in Coverage" final rule late last year pursuant to the Affordable Care Act's transparency requirements. The full text of the final rule is available here.

Specifically, the three separate machine-readable files will include the following information:

- the first will show negotiated rates for all covered items and services between the plan or issuer and in-network providers;
- the second will show both the historical payments to, and billed charges from, out-of-network providers; and
- the third will detail the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

Plans and issuers will have to display these data files in a standardized format and provide monthly updates.

For purposes of the cost-sharing disclosure requirements, the tri-Agencies will develop a list of 500 shoppable services that will need to be covered by the initial self-service tool that will have to be available for plan years beginning on or after January 1, 2023. All other relevant items and services (i.e., those not included in the initial 500 list) will need to be included in the tool for plan years beginning on or after January 1, 2024.

Who is responsible for compliance?

In the case of fully-insured plans, the final regulations provide that the health insurance issuer – and not the plan sponsor – will be responsible for complying with the rules if the plan sponsor and issuer have a written agreement for the issuer to provide the required information. While sponsors of self-insured plans can also contract with their third-party administrators to provide the information, the plan sponsor will nonetheless bear the responsibility of compliance.

Department of Labor Issues Missing Participants Guidance for ERISA Fiduciaries

ERISA retirement plan fiduciaries generally have an obligation to make "reasonable efforts" to locate missing participants so that they can claim any vested benefits remaining in the plan. This obligation has been a focal point for the Department of Labor's (DOL) enforcement efforts over the last several years and is currently the subject of a national enforcement initiative. The new guidance is intended to help fiduciaries of both defined benefit and defined contribution plans understand what they should be doing to fulfil their obligations with respect to finding missing and nonresponsive participants.

The new guidance is comprised of the following three separate documents:

- "Best Practices for Pension Plans," which provides a series of examples illustrating "best practices" that, according to the DOL, "have proven effective at minimizing and mitigating the problem of missing or nonresponsive participants";
- Compliance Assistance Release 2021-01, which outlines DOL's general investigative approach under the Terminated Vested Participants Project (i.e., the national enforcement initiative mentioned above, which applies only to defined benefit plans); and
- Field Assistance Bulletin 2021-01, which authorizes fiduciaries of terminating defined contribution plans to use the PBGC's missing participants program for missing or nonresponsive participants account balances.

Overview of Best Practices Guidance

While all three documents are helpful, the "Best Practices for Pension Plans" guidance is notable for highlighting what DOL believes are "red flags" that should put a plan's fiduciaries on notice that they may have a missing participants problem, and what they can do to "right the ship" or – even better – avoid problems in the first place. Even though DOL's enforcement efforts to date have focused primarily on defined benefit plans, the best practices are specifically applicable to defined contribution plans as well.

Some of the "red flags" DOL identifies include more than a small number of missing or nonresponsive participants or terminated vested participants who have not started receiving their benefits, and the absence of sound policies and procedures for handling returned mail and uncashed checks.

The examples are grouped into four categories, as summarized below.

1. **Maintaining accurate census information for the plan's participant population**. Best practice examples here include contacting current and retired participants and beneficiaries on a regular basis to confirm or update their contact information, including contact change information in regular plan communications, and providing prompts to participants and

beneficiaries to confirm or update contact information when they log in to online platforms.

2. Implementing effective communication strategies. Some of the best practice examples here include stating upfront and prominently what a communication is about (e.g., eligibility to begin distributions, request for updated contact information, etc.), using plain language and offering non-English language assistance when appropriate, and building steps into onboarding and enrollment processes for new employees as well as exit processes for separating or retiring employees to confirm or update their contact information.
3. Missing participant searches. Directly addressing the question of how far a plan fiduciary should go to track down participants who are not responding, the best practices cited include checking related plan and employer records for participant, beneficiary, and next of kin/emergency contact information, checking with designated plan beneficiaries for updated contact information, and reaching out to the missing participant's colleagues.
4. Documenting procedures and actions. Examples of best practices here include putting the plan's relevant policies and procedures in writing to ensure clarity and consistency, documenting key steps and actions taken, and ensuring any third-party recordkeepers are performing relevant agreed upon services.

Significantly, the DOL guidance document acknowledges that not every example provided will be appropriate for every plan. Accordingly, the guidance provides:

> Responsible plan fiduciaries should consider what practices will yield the best results in a cost-effective manner for their plan's particular participant population. In deciding what steps are appropriate, plan fiduciaries should also consider the size of a participant's accrued benefit and account balance as well as the cost of search efforts. The specific steps taken to locate a missing participant, or to obtain instructions from a nonresponsive participant, will depend on facts and circumstances particular to a plan and participant.

Next Steps

Given DOL's ongoing commitment to enforcement, ERISA retirement plan fiduciaries may consider using the guidance documents as an opportunity to review their current procedures for locating missing participants, identify gaps, and design and implement any changes that might be needed.

CAA Includes New Mental Health Parity Reporting Requirement

Among the Consolidated Appropriation Act's (CAA) transparency requirements for group health plans is a new reporting requirement for group health plans relating to compliance with Mental Health Parity rules for nonquantitative treatment limitations ("NQTLs").

Effective as of December 27, 2020 (the date the CAA was enacted), group health plans or issuers of group health coverage must perform and document comparative analyses of the design and application of the plan's NQTL's for medical and surgical and mental health or substance use disorder benefits. This comparative analysis, along with specific information discussed below, must be given to the appropriate state authority, or to the Secretary of Labor, HHS, or Treasury, as applicable, upon request.

Background

Briefly, group health plans that offer mental health or substance use disorder benefits may not impose more stringent limitations on such benefits than those that apply to medical and surgical benefits. This parity requirement does not just apply with respect to cost-sharing requirements and numeric limits on visits to specific types of providers, but also to NQTLs such as medical management and pre-authorization requirements. These NQTL rules are complex and can pose unique compliance and enforcement challenges.

What Does the New Rule Require?

If asked by the relevant regulatory authority for its comparative analyses, the plan or issuer also will have to provide:

- The specific plan or coverage terms regarding NQTLs;
- The factors used to determine that the NQTLs will apply;
- The evidentiary standard used for each factor; and
- The specific findings and conclusions reached, including anything indicating whether the plan is or is not in compliance with the relevant requirements.

Under the terms of the statute, plans are supposed to complete the comparative analyses by February 10, 2021 (i.e., 45 days after December 27, 2020, the date the CAA was enacted). However, plans are not required to do anything with the analyses until the Secretary or some other regulatory authority requests them. If the Secretary decides a plan fails to meet the NQTL requirements, it generally will be given 45-days to come into compliance. If the Secretary determines the plan still isn't compliant after 45 days, it will notify the plan's participants.

The CAA requires regulators to issue compliance program guidance, with examples of mental health parity compliance and noncompliance. This compliance guidance program will be updated every 2 years.

The CAA also directs the regulators to issue guidance on the new requirements but does not provide a deadline for them to do so. It also requires them to finalize any draft or interim guidance and interim regulations relating to mental health parity within 18 months, or by June 2022.

Watch the Rewards Policy Insider for additional updates.

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