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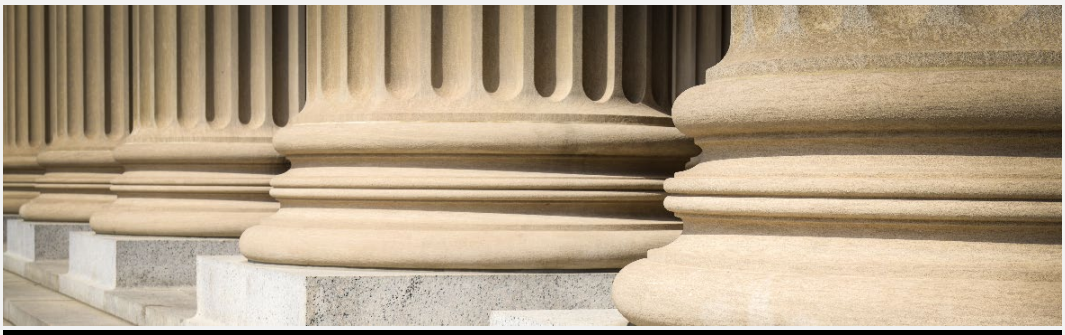

Rewards Policy Insider
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In this Issue:

DOL Announces Non-Enforcement Policy for Trump-Era ESG Investments and Proxy Voting by Employee Benefit Plans Rules

Pursuant to an Executive Order by President Biden, the Department of Labor on March 10 formally announced its plans to revisit the ESG and Proxy Voting rules. In the meantime, DOL said it will not enforce either final rule.

The ESG ("Environmental, Social, and Corporate Governance") rules, which were adopted in November 2020, modified ERISA's "Investment Duties" regulation to require plan fiduciaries to make investment decisions solely on the basis of "pecuniary factors."

The Proxy Voting by Employee Benefit Plans final rule, adopted in December 2020, also modified the "Investment Duties" regulation to address ERISA fiduciary obligations when voting proxies and exercising other shareholder rights in connection with plan investments in stock.

According to the DOL's March 10 notice, various stakeholders – including asset managers, investment advisors, labor organizations, and plan sponsors – have asked whether these rules properly reflect ERISA's fiduciary requirements. Additionally, the notice states stakeholders have wondered if the rules were "rushed," and therefore "failed to adequately consider and address the substantial evidence submitted by public commenters on the use of ESG considerations in improving investment value and long term investment returns for retirement investors." Finally, the notice says the final rules have had a "chilling effect" on appropriate uses of ESG factors in investment decisions.

As a result, the notice concludes "Until it publishes further guidance, the Department will not enforce either final rule or otherwise pursue enforcement actions against any plan fiduciary based on a failure to comply with those final rules with respect to an investment, including a Qualified Default Investment Alternative, or investment course of action or with respect to an exercise of shareholder rights."

The DOL's notice is available here.

Updated Guidance on Mandatory Coverage for COVID-19 Testing and Vaccines

The Centers for Medicare and Medicaid Services (CMS), along with the Departments of Labor and Treasury, on February 26 issued an updated set of FAQs relating to group health plans' obligations to cover COVID-19 testing and vaccinations. A particular focus of the new FAQs is emphasizing that group health plans cannot impose cost-sharing for COVID-19 testing on participants who are asymptomatic and have no known or suspected COVID-

19 exposure if the test is received from, or referred by, a licensed or authorized health care provider.

COVID Testing Mandate

Pursuant to the Families First Coronavirus Response Act ("FFCRA") and the Coronavirus Aid, Relief, and Economic Security ("CARES") Act, group health plans and health insurance issuers of group coverage must cover coronavirus testing without any cost-sharing or prior authorization or other medical management requirements (e.g., medical necessity). This requirement is effective from March 18, 2020 until the end of the federally-declared COVID public health emergency.

The FAQs provide:

> When an individual seeks and receives a COVID-19 diagnostic test from a licensed or authorized health care provider, or when a licensed or authorized health care provider refers an individual for a COVID-19 diagnostic test, plans and issuers generally must assume that the receipt of the test reflects an "individualized clinical assessment" and the test should be covered without cost sharing, prior authorization, or other medical management requirements.

The FAQs also confirm these rules apply if the test is received at a state- or locality-administered site, a "drive-through site," and/or a site that does not require appointments.

The guidance distinguishes testing in these circumstances (i.e., diagnostic testing) from testing for public health surveillance or employment purposes (e.g., as part of a "return to work" program). In the latter case, the coverage mandate does not apply. However, as the FAQs point out, there is no limitation on plans providing coverage for non-diagnostic testing if they choose to do so.

COVID Vaccine Mandate

The CARES Act also requires group health plans and health insurance issuers of group coverage subject to the Affordable Care Act's (ACA) preventive services mandate to cover certain qualifying coronavirus preventive services, including coronavirus vaccinations, without any deductible, copay, coinsurance, or other cost-sharing.

Unlike other preventive services that group health plans must cover under the ACA, the qualifying coronavirus preventive services mandate for COVID vaccinations has an accelerated effective date of no more than 15 business days after a vaccine receives an A or B rating from the U.S. Preventive Services Task Force or is recommended by the CDC's Advisory Committee on Immunization Practices (ACIP). For other newly approved preventive services plans generally do not have to begin offering coverage without cost sharing until the first plan year that begins after the one-year anniversary of the new rating or recommendation.

For example, ACIP issued an interim recommendation for use of the Pfizer vaccine on December 13, 2020. As a result, group health plans and issuers had to start covering the Pfizer vaccine without any cost-sharing on January 5, 2021 – i.e., 15 business days after the ACIP recommendation. The ACIP interim recommendation for the Janssen vaccine was issued on March 2, which means the mandate started to apply on March 23. Of course, a plan can start providing coverage without any cost-sharing as soon as a vaccine starts being administered even if that happens before this 15-day period has run.

Another key difference between the qualifying coronavirus preventive services mandate and the normal ACA preventive services mandate is that the former applies regardless of whether the participant receives the vaccine from an in-network or out-of-network provider.

The FAQs acknowledge that the CDC and state and local governments have established prioritization criteria to help determine when people should be eligible to receive the vaccine. The FAQs confirm that plans may not deny coverage for someone who gets the vaccine earlier than they might be eligible if some or all of these criteria were applied.

However, if a provider refuses to administer a vaccine to someone based on these prioritization criteria, the FAQs clarify that the participant does not have a claim for benefits that must be resolved through the plan's claims procedures, including internal and external appeals processes.

Like the testing mandate discussed above, the coronavirus preventive services mandate will sunset when the federally-declared COVID public health emergency ends.

The FAQs are available on the CMS website.

Summary of "Surprise Billing" Ban in CAA

This final installment in a series of articles focusing on the group health plan-related provisions in the Consolidated Appropriations Act (CAA), 2021, features new restrictions on "surprise billing" for emergency and air ambulance services. These new requirements will apply to plan years beginning on or after January 1, 2022.

Broadly speaking, the CAA provisions tackle the surprise billing issue on three different fronts:

1. What prior authorization and cost-sharing requirements the plan can impose on participants;
2. The amount providers and facilities can recover from plans for their services; and
3. What, if any, responsibility the participant/patient has to pay the provider for amounts the plan doesn't pay.

Plan Coverage and Cost-Sharing Requirements

Under the new rules, group health plans and issuers of group coverage that provide coverage for emergency services may not impose any prior authorization requirement for such services and must cover such services regardless of whether they are provided by an in-network provider or facility. If a participant receives emergency services from a non-participating provider or facility, the plan must impose at least as favorable cost-sharing requirements on the participant as would have been applied if they had used a network provider or facility. If these requirements do not sound "new," it's because they

are very similar to the emergency services mandates included in the Affordable Care Act (ACA). But the similarities end there.

For example, the CAA requirement further provides that any cost-sharing paid by the participant must be applied towards the plan's in-network deductibles and out-of-pocket maximums. And if there are any disputes between the plan or issuer over whether these rules apply in a particular situation, they will be subject to the ACA's external review process.

Plan Responsibilities to Out-of-Network Providers and Facilities

When the out-of-network provider or facility bills the plan or issuer for the relevant services, the plan or issuer has 30 days to make an initial payment or issue a notice of denial of payment. Ultimately, the plan or issuer's responsibility will be the "out-of-network rate" less the participant's cost-sharing obligations. In general, the "out-of-network rate" for this purpose is the rate negotiated by and between the plan and provider or facility, or, if they can't agree, the amount determined by an independent dispute resolution process (IDPR) specified in the statute. However, in states that have a relevant rate set by law or an All Payer Model Agreement, then the state's rate will apply.

Can the Provider "Balance Bill" the Participant/Patient?

The end-goal of these reforms is to prevent the provider in these situations from looking to the participant for any difference between the provider's bill and the amount the plan pays – i.e., the "balance billing" amount. The new rules prohibit out-of-network facilities and providers from balance billing, or otherwise holding the group health plan participant responsible, for any amount more than the cost-sharing amounts the plan is permitted to impose in these circumstances under these requirements.

What Else Should Group Health Plans Know?

The law adds similar balance-billing restrictions and related requirements for non-emergency services provided to a plan participant at a network facility by a non-participating provider.

Additionally, a comparable set of rules will apply to air ambulance services that a participant receives from an out-of-network provider.

Significantly, the bill also amends the Affordable Care Act (ACA) to specifically apply these surprise billing requirements to grandfathered group health plans for plan years beginning on or after January 1, 2022. That includes the bill's provisions relating to direct access to OB/GYN services and designating a pediatrician or OB/GYN as a primary care provider, which will apply to grandfathered plans as well. This is a change from the original ACA requirements relating to coverage for emergency services, direct access to OB/GYN services, and designating a pediatrician or OB/GYN as a primary care provider, which are not applicable to grandfathered plans.

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