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Implementation Deadline Approaches for First Part of Transparency in Coverage Regulation

By July 1, 2022, non-grandfathered group health plans are required to publicly post to their websites standardized, machine-readable files with required information about in- and out-of-network rates.

Machine Readable Files

The Transparency in Coverage ("TinC") final regulation is generally effective as of January 1, 2022, but the regulatory agencies have delayed implementation of some requirements, and deferred others.

Specifically, the agencies delayed until July 1, 2022 the requirement for group health plans to publicly disclose – in two separate machine-readable files – information about in-network provider rates for covered items and services, and out-of-network allowed amounts and billed charges for covered items and services. The data files must be displayed in a standardized format as specified in the regulation and must be updated monthly. Per the regulation, "The machine-readable files must be publicly available and accessible to any person free of charge and without conditions, such as establishment of a user account, password, or other credentials, or submission of personally identifiable information to access the file."

The TinC final regulation also requires a third machine readable file, which provides negotiated rates and historical net prices for covered prescription drugs. However, the agencies have indefinitely deferred this requirement due to its overlap with new prescription drug reporting requirements enacted pursuant to the Consolidated Appropriations Act, 2021 ("CAA"). The initial prescription drug report is due by December 27, 2022.

Price Comparison Tool

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.*

Recognizing that plans and health insurance issuers had 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 regulators have deferred enforcement of the related CAA provisions until plan years beginning on or after January 1, 2023.*

Limited Final Revisions to Form 5500 Released

Following proposed revisions published in September 2021, on May 20, 2022, the Department of Labor ("DOL"), Treasury Department, and Pension Benefit Guaranty Corporation (collectively, "the agencies") published a limited set of final revisions to the Form 5500 annual report for employee benefit plans.

Background

As reported in a previous edition of Rewards Policy Insider, on September 14, 2021, the agencies published a Notice of Proposed Form Revisions to the Form 5500 Annual Return/Report as well as an accompanying Notice of Proposed Rulemaking. The extensive proposed revisions to the Form 5500 included many required by the SECURE Act. The proposed revisions would, among other things, implement a new aggregate annual reporting option for certain groups of structurally identical defined contribution plans ("DCGs") via a new Schedule DCG; implement a new Schedule MEP for purposes of additional reporting for multiple employer plans ("MEPs"), including pooled employer plans ("PEPs"); and add a series of new questions to the Form 5500.

The proposed revisions and regulations would also make changes to the reporting requirements for multiple employer welfare arrangements ("MEWAs"). MEWAs that are subject to ERISA and provide group health benefits generally must file both the Form 5500 and the Form M-1, while MEWAs that are not subject to ERISA are only required to file the Form M-1. The Form 5500 requires plans to include certain information with respect to each employer participating in the MEWA, but the Form M-1 currently does not require such information. The proposed revisions and regulations would require all MEWAs filing the Form M-1 to provide participating employer information if the MEWA provides group health benefits. In addition, MEWAs that are also subject to the Form 5500 filing requirements would not be required to provide participating employer information as an attachment to their 5500s.

Final Revisions

The final revisions are limited in scope and address only a portion of the revisions that were proposed in September 2021. The final revisions primarily implement reporting changes for defined benefit plans, such as amendments to Schedule MB and Schedule R affecting multiemployer defined benefit plans. The final revisions also add new plan characteristic codes in the Form 5500 and clarify the Form 5500 instructions for MEPs. The revisions are effective for plan years beginning on or after January 1, 2022.

Importantly, the agencies noted in the final revisions that they are "still evaluating public comments" on a number of key elements of the September 2021 proposals, including DCG reporting requirements for filing a consolidated Form 5500; the new Schedule MEP; changes to Schedule H and Schedules of Assets; changes in participant count methodology; the addition of IRS compliance questions; and changes regarding reporting on participating employers for MEWAs that file the Form M-1. With respect to these issues, the agencies indicated that they need additional time to consider the range of public comments that they received, and that they want to develop final rules

that are cost-effective and improve the annual report data in a way that is protective of the retirement security interests of participants and beneficiaries. The agencies stated that the issues that have not yet been addressed will be addressed either in a further final forms revisions notice based on the September 2021 proposals or re-proposed with modifications in a separate proposal that would focus on a broader range of improvements to the annual reporting requirements. One opportunity to re-propose revisions could be in a separate project to modernize the Form 5500, which DOL has listed on its semi-annual regulatory agenda.

Delaware Enacts Paid Family and Medical Leave Law

The number of states with paid family and medical leave laws keeps growing, with Delaware recently becoming the 11th state (plus the District of Columbia) to create a state-run program. Beginning in 2025, covered employers will begin paying into the state's Family and Medical Leave Insurance Account Fund, and benefits will start in 2026.

Background

Delaware is the second state, after Maryland, to enact a paid family and medical leave law in 2022. Nine other states, plus the District of Columbia, have enacted such laws since California was the first in 2002, mostly in the last decade.

The proliferation of these laws has created challenges for multi-state employers that must navigate different standards for the type and duration of leave, eligibility, payroll taxes, job protection, and options for establishing private plans in lieu of the state-run program.

Overview of New Delaware Law

In general, job-protected paid family and medical leave benefits will be available to Delaware employees who have been employed by the same employer for at least 12 months, and who completed at least 1,250 hours of service with that employer during the previous 12-month period. Paid family and medical leave will be available for any of the following reasons:

- Because of a birth, adoption, or placement through foster care of a child, the employee is caring for the child during the first year after the birth, adoption, or placement of the child ("Parental Leave");
- The employee is caring for a family member with a serious health condition ("Family Caregiving Leave"); or
- The employee has a serious health condition that makes him or her unable to perform the functions of the employee's position ("Medical Leave").

During any 12-month period (as defined in the federal Family and Medical Leave Act ("FMLA")), an eligible employee can take up to 12 weeks of paid Parental

Leave. In the case of 2 parents who work for the same employer, the employer can limit the couple to a total of 12 weeks of Parental Leave during the 12-month period. The maximum amount of Family Caregiver Leave or Medical Leave is 6 weeks in any 24-month period.

Employers will be subject to a payroll tax that will fund the program. However, employers can choose to require their employees to pay up to 50% of the payroll tax.

For 2025 and 2026, the total payroll tax rate will be 0.8%, and will be subject to annual actuarial adjustments in future years. However, under the statute the payroll tax rate can never exceed 1%.

Private Plan Option

Covered employers can apply to the Delaware Department of Labor for approval to provide the required benefits through a private plan. The private plan generally must provide the same minimum benefits as the Delaware program and can be self-insured. Employers also can choose a hybrid approach, whereby they provide some of the required benefits – e.g., Parental Leave – through a private plan, and the rest through the Delaware program.

Other Employer Considerations

The new program will require employers to bear much of the administrative burden associated with screening their employees for purposes of determining eligibility for paid family and medical leave. This will include collecting and keeping the information needed to verify parental leave status, serious health condition, or qualifying exigency. Additionally, employers will have to ask employees to obtain a health care provider certification of the employee's (or the employee's family member's) serious health condition. Employers also will have the ability to follow up if they have reason to doubt the validity of a certification.

Employers also will be required to provide written notice to employees of their rights to job-protected paid family and medical leave, procedures for filing claims, and whether benefits will be provided by the Delaware program or through a private plan.

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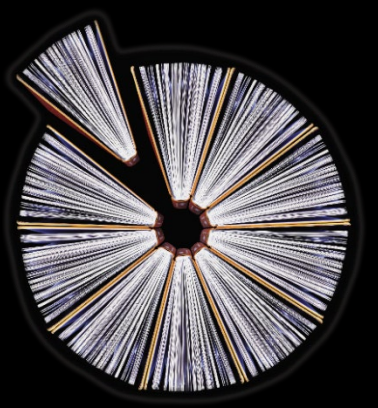

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