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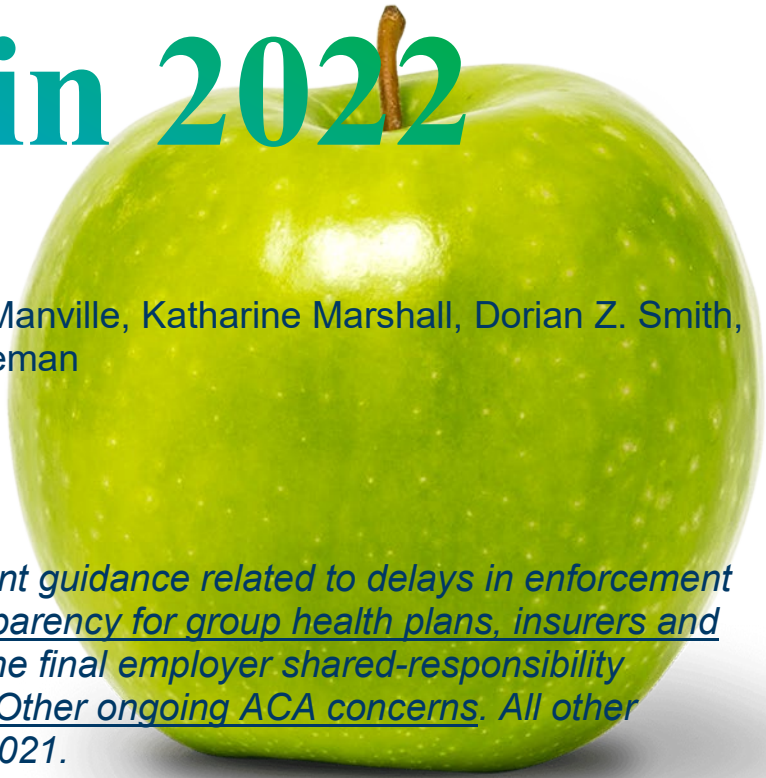
Top 10 compliance issues for health, fringe and leave benefits in 2022



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This revised document reflects recent guidance related to delays in enforcement and good faith compliance in Transparency for group health plans, insurers and hospitals and Surprise billing, and the final employer shared-responsibility affordability percentage for 2022 in Other ongoing ACA concerns. All other sections are current as of July 30, 2021.

welcome to brighter

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Health, fringe and leave benefit compliance issues for 2022

The COVID-19 pandemic — while more controlled in the US than this time last year — continues to produce unique challenges for planning and managing health, fringe, and leave benefits for 2022. Employers must continue managing their workforces as COVID-19 outbreaks recur, with some employees working remotely, some in hybrid arrangements and some in the workplace. Employers have a renewed focus on diversity and inclusion issues, especially those affecting employees' mental health and well-being.

Employers also must keep an eye out for policy changes. While the Biden administration has prioritized bringing the pandemic under control, a number of proposed reforms would affect health and leave programs. These proposals come after multiple COVID-19 laws enacted in 2020 and early this year require significant changes to health plans, including major new transparency standards and prohibitions on surprise medical bills. Regulators are racing to provide the extensive guidance employers need to comply with these requirements, many of which take effect beginning in 2022. In addition, states continue to enact laws that affect health and leave benefits. As a result, employers have major work to do in planning for 2022, even as the potential for additional legislative and regulatory changes looms in Washington, DC.

Legislative and regulatory outlook going into 2022

Democratic control of Congress and the White House has brought a flurry of health and paid leave proposals, with significant implications for employer programs. Key proposals include:

- **ACA and paid leave reforms.** President Biden has made expansion of the Affordable Care Act (ACA) a core tenet of his healthcare agenda, and the American Rescue Plan Act (ARPA) included a two-year increase and expansion of ACA marketplace plan subsidies. Biden and Democrats are looking to make these more generous subsidies permanent as part of a party-line spending bill they hope to pass this year. Other potential ACA changes include fixing the "family glitch" that ties employer plan affordability to self-only coverage, and narrowing the healthcare reforms states can pursue through innovation waivers. Creating a national paid leave program run by the federal government is also on the agenda.

- **Public healthcare reforms.** Progressive Democrats are championing more ambitious proposals, such as creating a public option plan to compete with private insurers, lowering the eligibility age for Medicare, letting Medicare negotiate drug prices, and expanding Medicare benefits to include dental, vision, and hearing coverage.

The outlook for these and even relatively moderate ACA changes is uncertain. Democrats might be able to pass party-line legislation without Republican support under a special budget reconciliation process. However, they could not afford to lose any votes among their own members in the 50-50 Senate or more than a few Democrats in the narrowly divided House. Hammering out final legislation to the satisfaction of different factions of Democrats will be a major challenge. Still, enactment of a major legislative package later this year is possible, so employers will need to monitor congressional developments.

Regardless of what happens in Congress, the Biden administration continues to pursue its health policy agenda through regulations and executive action. Regulators are issuing guidance on a multitude of new requirements — most recently, a rule implementing prohibitions on surprise medical bills. The Biden administration has not backed away from the 2020 transparency in coverage regulations that take effect beginning in Jan. 1, 2022, and has doubled-down on mental health parity enforcement. Much more guidance is expected over the next several months and into 2022. Employers will need to show good-faith compliance with the new requirements, even though some needed guidance may not come out until next year.

2022 health and leave benefit planning

This list highlights 10 top compliance-related priorities for planning 2022 health, leave, and fringe benefits and recommends general actions for each item. The links below take readers to more detailed information, while an appendix gives resources related to each compliance priority:

1. **COVID-19 issues for health plans.** COVID-19 considerations for group health plans will likely to continue into 2022, with the public health emergency, national emergency and related agency guidance still in place for now. When strategizing for 2022, employers should review the continuing coverage mandates, agencies' various COVID-19 relief, and 2021 communications to plan participants about pandemic-related covered benefits and relief from certain group health plan deadlines. Some employers may want to continue certain benefit enhancements beyond the required coverage period, while others may want to revert to prepandemic terms. In either case, communications with plan participants and plan documentation are essential. Opportunities to expand telehealth, employee assistance programs (EAPs) and on-site clinics may continue into 2022. Congress is working to make some temporary relief for telehealth programs permanent.

2. **Maintaining a safe, healthy workplace.** While the pandemic is more controlled than last year in many US states and other parts of the world, outbreaks are still happening in undervaccinated areas. Decide whether to encourage or mandate vaccines for employees returning to an on-site workplace. Consider whether to let workers continue working remotely all of the time or a few days per week or instead fully transition back to prepandemic work sites and schedules. Monitor local conditions, and prepare contingency plans as pandemic and economic conditions fluctuate. Recognize the need to have an operating plan for 2022 that values flexible work and reflects local pandemic conditions, while prioritizing employee safety, health, diversity and inclusion.

3. **Transparency for group health plans, insurers and hospitals.** Prepare to comply with final transparency in coverage rules for group health plans, along with several new transparency requirements under the 2021 Consolidated Appropriations Act (CAA), effective for plan years beginning on or after Jan. 1, 2022. Regulators recently issued guidance that delays enforcement for several compliance requirements, and plan to issue additional guidance on the CAA's transparency requirements. In the interim, plan sponsors must make good-faith efforts to comply with most requirements. Review the price disclosures that hospitals are making public in 2021 to comply with the final hospital transparency regulation.

4. **Surprise billing.** A federal law prohibiting surprise bills for certain services takes effect for providers (including air ambulances) and facilities on Jan. 1, 2022, and for group health plan years and individual or group health insurance policies beginning on or after that date. The No Surprises Act, adopted as part of the 2021 CAA, builds on parts of the ACA by creating comprehensive patient protections against surprise medical bills. A recently released interim final rule (Part I) provides employers and plan sponsors some compliance guidance, although additional regulations are expected later this year and in 2022. Employers should review the new law and rules and confer with third-party administrators (TPAs) and carriers to prepare plans for compliance. Plan administrators will need to adapt claims administration processes to comply with tight time frames, apply new cost sharing and provider-payment procedures, and provide new disclosures in plan documents and explanations of benefits (EOBs), among other requirements.

5. **Gender and family planning issues in benefits.** Consider whether the Supreme Court's decision in *Bostock v. Clayton County, Ga.* (40 S. Ct. 1731 (2020)), ACA Section 1557, the Mental Health Parity and Addiction Equity Act (MHPAEA), or state laws necessitate benefit changes for LGBTQ employees and their family members. For many employers, mere compliance with the law is no longer sufficient to meet diversity, equity and inclusion (DEI) goals. Improved family planning benefits can be an important part of DEI efforts, but employers should consider relevant compliance issues. Federal tax rules, ACA mandates and state laws pose compliance complications to consider when designing and administering fertility, adoption and surrogacy benefits.

6. **Mental health parity.** Ensure the plan has prepared the comparative analysis of nonquantitative treatment limitations (NQTLs) required by the 2021 CAA. Employers sponsoring fully insured plans should be able to rely on their insurers for this analysis. If a self-insured plan sponsor is not already in full compliance, consider strategic interim steps while working toward full compliance. Prepare a response plan to react immediately to a request from federal agencies for an NQTL comparative analysis. Include assistance with NQTL comparative analyses in any future requests for proposals (RFPs) and vendor contracts. Watch for additional guidance and litigation in 2022.

7. **HSA, HRA and FSA developments.** For 2022, prepare to discontinue changes made by temporary COVID-19 relief, unless future legislation or agency guidance extends or makes the relief permanent. Determine whether to continue (or adopt) the permanent enhancements to account-based plans made by the Coronavirus Aid, Relief and Economic Stimulus (CARES) Act and IRS guidance. Adopt Section 125 plan amendments for changes reflecting COVID-19 relief; the first amendments are due by Dec. 31, 2021. Update high-deductible health plans (HDHPs) and account-based plans for indexed dollar limits. Identify pre- or no-deductible health benefits,

programs or point solutions that could jeopardize an individual's eligibility to make or receive health savings account (HSA) contributions, and confirm strategy. Consider whether pending IRS regulations on individual-coverage health reimbursement arrangements (HRAs) or direct primary care arrangements (DCPAs) will affect benefit strategies and compliance efforts. Review future IRS guidance on medical expenses or the definition of tax dependent for any impact on account-based plans.

8. **State activity.** Review state laws raising concerns for group health and benefit plans. For insured plans, expect activity on benefit mandates for health insurers. State initiatives that could affect employers include an uptick in paid family and medical leave (PFML) and paid sick leave mandates, increased pharmacy benefit manager (PBM) regulations, and expanded telehealth laws. Prepare for 2022 reporting obligations. Monitor the ERISA preemption challenge to Seattle's hotel employee healthcare ordinance.

9. **Preventive services.** Confirm that nongrandfathered group health plans cover ACA-required in-network preventive services without any deductible, copay or other cost sharing. Modify preventive benefits for the 2022 plan year to reflect new or revised recommendations from the US Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and ACA guidance. Monitor the development of new COVID-19 preventive services or vaccines, which nongrandfathered health plans must cover without cost sharing on an expedited time frame. Under final rules upheld in 2020 by the Supreme Court, nongovernmental employers with sincerely held religious or moral objections to contraceptives may exclude ACA-mandated coverage of some or all women's contraceptives approved by the Food and Drug Administration (FDA). Monitor ongoing litigation that seeks to invalidate no-cost-sharing coverage of all ACA-mandated preventive services. Update plan documents, summary plan descriptions (SPDs), summaries of benefits and coverage (SBCs), and other materials as needed.

10. **Other ongoing ACA concerns.** Review 2022 group health plan coverage and eligibility terms in light of employer shared-responsibility (ESR) strategy, ESR and minimum essential coverage (MEC) reporting duties, and ACA benefit mandates. Determine whether changes made by the final grandfathered health plan rule published in December 2020 can help preserve grandfathered status (if applicable). Continue to calculate and pay the Patient-Centered Outcomes Research Institute (PCORI) fee for self-funded health plans, and manage medical loss ratio (MLR) rebates. Monitor ongoing litigation challenging various ACA provisions, including the obligation for nongrandfathered group health plans to cover ACA-required in-network preventive services without participant cost sharing.

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COVID-19 issues for health plans

Action

Review group health plan terms for COVID-19-related coverage, including testing, treatment and vaccines. Consider benefit options for employees ineligible for the group major-medical plan. Communicate any changes in plan terms, eligibility and election periods, and amend plan documents accordingly. Confirm proper administration of claims and appeals, special enrollment events under the Health Insurance Portability and Accountability Act (HIPAA), and COBRA election periods and payments in light of agency relief extending deadlines during the COVID-19 public health and national emergencies.

Specific steps

Confirm group health plan coverage complies with COVID-19 testing and vaccine coverage requirements in the Families First Coronavirus Response Act (FFCRA), the CARES Act and any applicable state mandates.

- During the public health emergency, confirm the group health plan (including a grandfathered plan) continues to cover COVID-19 testing and related services without any participant cost sharing, prior-authorization requirements or other medical-management standards whenever a licensed healthcare or otherwise authorized provider deems the testing medically appropriate.
  - Monitor renewals of the COVID-19 public health emergency. The secretary of the Department of Health and Human Services (HHS) authorizes the public health emergency for 90-day periods, unless terminated earlier. The COVID-19 public health emergency was first declared on Jan. 31, 2020, and has been renewed repeatedly, most recently on July 19, 2021. The secretary is expected to continue renewing the COVID-19 public health emergency into 2022.
  - Verify these coverage standards apply to COVID-19 testing and related services from both in- and out-of-network providers.
  - Confirm coverage extends to testing and related services conducted in nontraditional settings, like drive-through facilities or at home, in addition to urgent care centers, emergency rooms and telehealth consultations.
  - Ensure HDHPs — until further notice — cover COVID-19 testing and treatment on a predeductible basis, without affecting a participant's eligibility for HSA contributions. (For more on predeductible COVID-19 coverage in HDHPs, see HSA, HRA and FSA developments.)

- Consider whether the plan will cover COVID-19 testing and related services when conducted for general workplace or back-to-school screenings or in other circumstances (e.g., travel) exempt from a federal or state mandate or a cost-sharing ban. (For more on workplace strategies, see Maintaining a safe, healthy workplace.)

- Confirm continuing nongrandfathered group health plan coverage of COVID-19 vaccines (including administration) and other related preventive services without cost sharing. (For more on preventive care requirements, see Preventive services.)

  — Verify coverage without cost sharing extends to qualifying coronavirus preventive services received from out-of-network providers during the public health emergency. Consider whether the plan will limit this no-cost coverage to in-network providers once the public health emergency expires. Amend plan terms and employee communications accordingly.

  — Watch for new COVID-19 vaccine recommendations — including recommendations to administer already-approved vaccines to children — from ACIP or USPSTF Ensure plan coverage of newly recommended COVID-19 vaccines begins within 15 days.

  — Ensure HDHPs cover COVID-19 vaccines as preventive care on a preductible basis without affecting eligibility for HSA contributions. (For more on HSA eligibility and COVID-19 coverage, see HSA, HRA and FSA developments.)

  — Consider whether to offer incentives or mandates for employees to get vaccinated. (For more on this topic, see Maintaining a safe, healthy workplace.)

- For fully insured plans, confirm compliance with state COVID-19 coverage requirements that may go beyond federal requirements. For example, some states require coverage of COVID-19 treatments without cost sharing, and others have vaccine coverage requirements (see this report).

  — According to the Centers for Medicare & Medicaid Services (CMS), COVID-19 diagnosis and treatment are ACA essential health benefits (EHBs) covered by all state benchmark plans.

- Confirm with TPAs and insurers that coverage of COVID-19 testing and related services, vaccines, and associated administrative expenses continues without cost sharing as required.

  — Insurers and TPAs should have a consistent and clear process to evaluate claims and audit instances when plan participants have been balance-billed for these COVID-19 services.

  — Ensure the plan documents all compliance activities in case of agency enforcement.

Consider offering or covering COVID-19 vaccines through an on-site clinic, EAP or grandfathered plan, if not doing so already. Review whether a stand-alone COVID-19 vaccine

program would be an ERISA group health plan, and address any compliance concerns. (For a discussion of mandating workforce vaccinations, see Maintaining a safe, healthy workplace.)

- On-site clinics and most EAPs are excepted benefits exempt from the preventive-services coverage mandate but can offer COVID-19 vaccines. Grandfathered health plans also are exempt from the mandate. Nonetheless, CMS encourages these plans to cover COVID-19 vaccines without cost sharing for all enrollees.

- Agency guidance (FAQ 15) confirms that group health plans can maintain grandfathered status even if they later revoke benefits added during the public health emergency.

Review group health plan documents and communications about COVID-19 coverage.

- Decide whether to adopt plan amendments reflecting COVID-19 coverage changes to plan terms. Plan amendments normally must be adopted before the last day of the plan year to which they apply, absent guidance extending the deadline. In some cases, a summary of material modifications (SMM) can serve as the plan amendment.

- Consider whether the plan will continue to cover COVID-19 testing and related services, or vaccines from out-of-network providers, without cost sharing once the public health emergency has ended. If covering COVID-19 treatment without cost sharing, consider whether coverage terms will remain the same in the 2022 plan year and after the public health emergency expires.

  — If coverage terms will change after the public health emergency expires, prepare communications to distribute at least 60 days before the change, unless prior communications indicated the general duration of the additional covered services and reduced cost sharing.

  — If coverage enhancements will continue beyond the public health emergency, amend plan documents and communicate changes to employees (e.g., through the SBC, SPD or SMM).

Review expanded telehealth, EAP and on-site clinic benefits.

- Keep in mind that agency guidance (FAQ 14) provides only temporary relief from many ACA group market reforms for large employers adopting stand-alone telehealth programs to offer employees ineligible for any other employer group health plan during the public health emergency.

  — Review compliance considerations with counsel, as certain ACA and ERISA requirements will still apply to stand-alone telehealth programs.

  — For any stand-alone telehealth program adopted during the public health emergency, prepare for expiration of the temporary relief from specific ACA group market reforms. Watch for developments from Congress or regulators that may provide more permanent relief.

- Review telehealth plan coordination with HDHPs. For plan years beginning on or before Dec. 31, 2021, HDHPs can cover telehealth services on a predeductible basis, and telehealth coverage outside of the HDHP will not jeopardize HSA eligibility.

  - For 2022 plan years, adjust coordination so telehealth services are not provided predeductible or outside of the HDHP, unless Congress or the agencies extend the temporary relief.

  - Prepare amendments to plan documents and revise employee communications accordingly. (For more details, see HSA, HRA and FSA developments.)

- Review excepted-benefit EAPs that include COVID-19 diagnostic and testing services, as permitted during the public health or national emergency.

  - To preserve excepted-benefit status post-pandemic, amend plan terms to discontinue these COVID-19 services, which might be deemed "significant benefits in the nature of medical care."

- Review on-site medical clinic benefits.

  - Keep in mind that employer-sponsored on-site medical clinics are excepted benefits in all circumstances, so they can readily expand offerings to include COVID-19 vaccines, testing and related services for all employees.

Consider adding coverage of personal protective equipment (PPE) to health flexible spending arrangements (FSAs) or HRAs, if not covered already.

- COVID-19 PPE — including masks, hand sanitizer and wipes used for the primary purpose of preventing the spread of COVID-19 — is considered medical care under Section 213 of the Internal Revenue Code. The cost of COVID-19 PPE can be paid by a group health plan or reimbursed under a health FSA, HRA, or HSA.

- Coverage or reimbursement of COVID-19 PPE expenses incurred after Jan. 1, 2021, requires a plan amendment that can apply retroactively if adopted before Dec. 31, 2022.

Adopt cafeteria plan amendments for changes in the 2021 CAA and IRS COVID-19-related relief, even if the changes are temporary.

- Amend a cafeteria plan by Dec. 31, 2022, if it implemented IRS relief waiving the normal Section 125 restrictions to allow midyear changes to medical, dental and vision coverage elections during calendar-year 2021. The amendment can apply retroactively to the first day of the plan year beginning on or after Jan. 1, 2021.

- For calendar-year plans implementing the CAA relief for health FSAs and dependent care assistance programs (DCAPs), adopt amendments by Dec. 31, 2021. For noncalendar-year plans, adopt similar amendments by Dec. 31, 2022. (For more information on the CAA relief for FSAs and DCAPs, see HRA, HSA, and health FSA developments.)

Review administration of delayed COBRA elections or premium payments, HIPAA special enrollment elections, and benefit claims and appeals. Make corrections where necessary.

- Ensure plan participants and COBRA-qualified beneficiaries have extended time during the COVID-19 emergency to meet certain time-sensitive tasks, such as electing HIPAA special enrollment or COBRA coverage, paying COBRA premiums, and filing benefit claims or appeals. Disaster relief notices 2021-01 and 2020-01, along with a joint agency notice, require plans to pause counting down the deadlines for these participant actions during the outbreak period.
  - The outbreak period runs from March 1, 2020, through 60 days after the end of the COVID-19 national emergency. The current national emergency will expire at the end of February 2022, unless ended earlier or extended again. Individual and plan deadlines subject to outbreak period relief will be paused until the earlier of (i) one year from the date a particular individual or plan was first eligible for relief or (ii) 60 days from the end of the COVID-19 national emergency (i.e., the end of the outbreak period).
- Verify that plan participants and COBRA beneficiaries are receiving communications about the extended deadlines. Ask vendors whether they are communicating the extended timing requirements in claim denial notices, EOBs, as well as HIPAA and COBRA notices during the outbreak period.
  - Determine whether any previous communications about deadlines need correction in light of the ongoing outbreak period relief. Review and amend plan documents and SPDs as necessary, particularly since the outbreak period will likely continue into 2022.
  - Decide whether, when and how to provide plan participants, COBRA qualified beneficiaries and others notices identifying deadlines related to the end of each individual's relief period.
- Confirm that health plan administrators are properly accommodating participants eligible for HIPAA special enrollment and allowing plan participants and beneficiaries extra time to file benefit claims and appeals or to request external review of a denied claim.
- Check that COBRA administrators are properly accommodating delayed elections or premium payments during the outbreak period. Increased COBRA-related litigation makes improper administration a heighted compliance risk.
  - Consider consulting legal counsel and the plan's COBRA administrator, claims administrator and/or stop-loss carrier to ensure compliance with claim processing and COBRA premium-payment regulations during the outbreak period. Confirm responses to provider inquiries about COBRA status are handled in a timely and consistent manner.
  - Confirm COBRA administrators are managing the outbreak period relief in combination with ARPA's COBRA subsidy and second enrollment opportunity. Review communications about the second enrollment opportunity and its effect on an individual's extended opportunity to elect and pay for COBRA coverage retroactive to the qualifying event under the outbreak period relief, and confirm appropriate COBRA administration.
- File proper forms with IRS to ensure reimbursement of the COBRA subsidy.

- Confirm COBRA election notices are provided in a timely manner, despite the relief allowing plans extra time to distribute notices. Delays in distributing COBRA election notices may further extend the election period, complicating administration even more.
  - Note that updated model COBRA general and election notices from the Department of Labor (DOL) do not address the COVID-19-related relief. To reduce the litigation risk for insufficient notices, health plan sponsors may want to use the most recent models but add information about the extended timelines during the outbreak period.
- Watch for additional agency guidance or clarifications, particularly on the operation of relief periods when the outbreak period comes to a definitive end.

Confirm compliance with ERISA notice and disclosure requirements, both during and after the outbreak period.

- Provide any ERISA-required notices and disclosures "as soon as administratively practicable under the circumstances" during the outbreak period, as permitted by the disaster relief notices. The guidance also allows electronic-delivery methods, such as text messages, emails or website postings, as long as the sponsor reasonably believes recipients can easily access those means of communication.
  - Consider using digital means to provide these notices since the e-delivery rules are relaxed during the outbreak period. But exercise caution about using electronic communications for individuals who don't have access to the employer's intranet or email or if the employer cannot confirm actual receipt.
  - Discuss the extended deadlines for issuing SMMs and other updated documents and communications with legal counsel. Keep in mind the potential liability for untimely or inadequate ERISA notices and disclosures about important plan rights.
- Resume normal distribution methods and timelines for providing ERISA notices and disclosures after the outbreak period. Limit electronic distributions to circumstances that satisfy DOL's electronic safe harbor rules.

Watch for additional agency guidance providing new or extending current COVID-19 relief that could affect employer benefits in 2022.

- Look for future agency guidance extending, modifying or creating new COVID-19 relief for plans and/or participants if the pandemic continues into 2022. Further relief is possible if the public health emergency continues or the national emergency is renewed.
- Monitor developing agency guidance, and prepare to adjust employee benefits and plan administration as necessary.

Related resources

2

Maintaining a safe, healthy workplace

Action

Decide whether to encourage or mandate COVID-19 vaccines or continue virus screening or testing for employees returning to on-site work. Remain ready to respond when an employee shows symptoms or tests positive. Consider whether to make remote or hybrid work a permanent feature. Keep diversity and inclusion in mind when making workforce decisions in light of the pandemic. Update 2022 operating plans for evolving local conditions and changes in federal, state, and local COVID-19 guidance on employee health and safety. Recognize that guidelines vary, depending on the size and type of employer, workforce, industry, working conditions, budget, employees' vaccination status, and local pandemic conditions. Ensure benefit programs bolster employees' and their families' health (including behavioral health) and financial wellness. Regularly review the efficacy of operating plans, stay updated on new guidance, consult experts as needed and have contingency plans for changing conditions.

Specific steps

Regularly review federal, state and local workplace safety and health guidance, and consult experts as needed. Pay attention to state and local guidelines, which may require masks indoors or screening workers with temperature checks or health questionnaires (and may be less stringent for fully vaccinated employee). Plan to revisit all guidance for updates as outbreaks fluctuate, particularly in undervaccinated pockets of the US and other countries. Here are some key federal pandemic resources to help employers navigate workplace issues:

- **CDC.** The CDC's COVID-19 webpage has health and safety information for businesses and workplaces, including specific occupations. Recently updated CDC guidance addresses fully vaccinated people in settings other than healthcare. Special rules likely apply to employers with healthcare, long-term care, assisted living or nursing home workers; first responders; or law enforcement personnel. Important resources for reopening workplaces include:
  - Resuming business toolkit
  - FAQs for businesses
  - Testing in nonhealthcare workplaces

- **Occupational Health and Safety Administration (OSHA).** OSHA's COVID-19 webpage includes FAQs on protecting during the COVID-19 pandemic, guidance on mitigating and preventing the spread of COVID-19 in the workplace, and an emergency temporary standard (ETS) for healthcare settings that took effect June 21, 2021. According to OHSA, if all employees in a workplace are fully vaccinated, then most employers no longer need to take steps to protect against COVID-19 exposure at work. Other OSHA resources available include:
  - Guidance on preparing workplaces for COVID-19 (Spanish version)
  - Worker exposure risk to COVID-19 (Spanish version)
  - Prevent worker exposure to coronavirus (COVID-19) (Spanish version)
  - COVID-19 guidance for retail workers (Spanish version)
  - Topic list of all OSHA COVID-19 publications
  - Relevant OSHA standards for COVID-19
  - Temporary enforcement guidance during the COVID-19 pandemic

Recognize whether specific health and safety mandates apply to your workplace, regardless of employees' vaccination status. Examples include healthcare settings covered by OSHA's ETS, public transportation workers subject to mask requirements, or those subject to other federal, state, local, tribal, or territorial laws, rules, and regulations for COVID-19 prevention.

Take steps to protect unvaccinated or otherwise at-risk workers in the workplace. Absent a vaccine mandate, most employers probably won't have a fully vaccinated workforce and will need multilayered interventions to protect the unvaccinated. In addition, some fully vaccinated workers — such as the immunocompromised — have higher risks for breakthrough infections. Here are some steps OSHA has provided:

- Grant paid time off for employees to get vaccinated.
- Instruct any workers who are infected, unvaccinated workers who have had close contact with someone who tested positive for COVID-19, and all workers with COVID-19 symptoms to stay home to reduce the risk of COVID-19 transmission.
- Implement physical distancing for unvaccinated and other at-risk workers in all communal work areas.

Review federal, state and local guidance on workplace anti-discrimination issues that may arise during the pandemic.

- **Ensure workplace practices do not discriminate against applicants or employees because of their race, color, religion, sex (including pregnancy, gender identity and sexual orientation), national origin, age (40 or older), disability, or genetic information.** Comply with other federal, state and local laws that may provide additional protections. The Equal Employment Opportunity Commission (EEOC) enforces several federal laws on workplace nondiscrimination:

  - The Americans with Disabilities Act (ADA) and the Rehabilitation Act require nondiscrimination toward and reasonable accommodations for applicants and employees with disabilities, including those with "long COVID." The laws also restrict employee medical exams and inquiries. (Both laws also have accessibility standards administered by the Justice Department.)

  - Title VII of the Civil Rights Act prohibits discrimination based on race, color, national origin, religion and sex (including gender identity, sexual orientation and pregnancy).

  - The Age Discrimination in Employment Act (ADEA) prohibits age discrimination against workers 40 or older.

  - The Genetic Information Nondiscrimination Act (GINA) prohibits discrimination based on genetic information, including family medical history.

- **Review key EEOC resources related to the pandemic:**

  - **Pandemic preparedness in the workplace and the Americans with Disabilities Act.** This resource, while subject to change as conditions evolve, provides guidance on a number of important questions, including:

    - ***How much information from an ill employee may an employer request to protect the rest of its workforce during a pandemic?*** If an employee reports feeling ill at work or calls in sick, the employer may ask about the employee's symptoms to determine if the individual has or may have COVID-19.

    - ***May an ADA-covered employer take employees' body temperature during a pandemic?*** Yes. Like all medical records, information about an employee's fever or other symptoms is subject to ADA's confidentiality requirements.

    - ***Does the ADA let employers require employees to stay home if they have COVID-19 symptoms?*** Yes, an employer can send an employee with COVID-19 symptoms home.

    - ***When employees return to work, may employers require doctors' notes certifying fitness for duty?*** Yes. These return-to-work requirements either are not ADA-prohibited disability-related inquiries or are justifiable — due to the severity of the pandemic — disability-related inquiries under the ADA standards.

- ***When an employee returns to work after travel, must the employer wait until the employee develops symptoms to ask questions about exposure to COVID-19 during the trip?*** No, these types of questions would not be disability-related inquiries. When the CDC or state/local public health officials recommend that people returning from specified locations remain at home until it is clear they do not have COVID-19 symptoms, employers may ask whether employees visited these locations, even if the travel was personal.

- ***Hiring guidelines*.** The EEOC guidance includes a number of Q&As about hiring practices in light of the COVID-19 pandemic.

— **What you should know about COVID-19 and the ADA, the Rehabilitation Act, and other EEO laws.** This resource includes periodically updated FAQs about vaccines, vaccine incentives, confidential COVID-19 screening and testing of employees, and other important information, including:

- ***May an employer require all employees entering an on-site workplace to be vaccinated for COVID-19?*** Yes, subject to the reasonable accommodation provisions of Title VII and the ADA and other EEO considerations. This policy can apply regardless of whether an employee gets the vaccine from the employer or elsewhere. An employer may need to provide reasonable accommodations for employees who do not get vaccinated because of a disability or a sincerely held religious belief, practice, or observance. However, employers do not need to make an accommodation if doing so would pose an undue hardship on business operations. Employers must not apply a vaccine requirement in a way that treats employees differently based on disability, race, color, religion, sex (including pregnancy, sexual orientation and gender identity), national origin, age, or genetic information, unless a legitimate nondiscriminatory reason justifies the disparate treatment.

- ***What are some examples of reasonable accommodations or modifications that employers may have to provide to employees who do not get vaccinated due to disability; a religious belief, practice or observance; or pregnancy?*** An unvaccinated employee entering the office might have to wear a face mask, work at a social distance from co-workers or nonemployees, work a modified shift, get periodic COVID-19 tests, telework, or accept a reassignment.

- ***How can employers encourage employees and their family members to get vaccinated without violating nondiscrimination laws, especially ADA and GINA?*** Employers may provide information to educate employees and their family members and to address questions and concerns about COVID-19 vaccines and their benefits. Under certain circumstances, employers may offer incentives for employees to receive COVID-19 vaccines, which are currently available at no cost to everyone ages 12 and older:

  - Under ADA, when an employer or its agent administers the vaccines, the employer may offer a reward to employees for getting vaccinated or a penalty for failing to do so. However, the incentive cannot be so substantial as to create coercion. Because the prevaccination process involves disability-related screening questions, a very large

incentive could make employees feel pressured to disclose protected medical information. But no incentive limits apply if employees voluntarily provide documentation or other confirmation that they received a COVID-19 vaccine from a third-party provider unaffiliated with their employer.

- Under GINA, as long as an employer does not acquire genetic information while administering the vaccines, it may offer incentives to employees for getting vaccinated. Because the prevaccination medical screening questions for the three COVID-19 vaccines now available do not inquire about genetic information, employers may offer employees incentives for getting vaccinated. Employers likewise may offer employees incentives to provide documentation or other confirmation of vaccination by a third party not acting on the employer's behalf, such as a pharmacy or health department.

- ***May an employer require COVID-19 vaccines for all employees entering an on-site workplace, even though the employer knows that some employees may not get a vaccine because of a disability?*** Yes, under certain conditions. Under ADA, an employer may require all employees to meet a qualification standard that is job-related and consistent with business necessity. This includes a safety-related standard requiring COVID-19 vaccination. However, if an employee cannot meet such a safety-related standard because of a disability, the employer may not require the employee to comply unless a demonstrable "direct threat" to the health or safety of the employee or others in the workplace exists. A "direct threat" is a "significant risk of substantial harm" that cannot be eliminated or reduced by reasonable accommodation.

Review federal, state and local guidance on COVID-19 leave and other leave laws, including sick leave, vaccine-related time off, leave to care for a family member or quarantine leave.

- Review federal guidance for employers on pandemic-related issues from the DOL's Wage and Hour Division, including:
  - Essential protections during the COVID-19 pandemic
  - COVID-19 and the Fair Labor Standards Act (FLSA) Q&As
  - COVID-10 and the Family and Medical Leave Act (FMLA) Q&As
  - FFRCA Q&As (for employers with less than 500 employees)
- Monitor state and local leave guidance, using references like Mercer's regularly updated GRIST, States, cities tackle COVID-19 paid leave.

Monitor local conditions using tools like Oliver Wyman's COVID-19 Pandemic Navigator, and stay on top of local workplace guidelines and restrictions.

- Review any local restrictions due to the pandemic or outbreaks, such as stay-at-home or shelter-in-place orders, mask mandates, or shutdowns or restrictions affecting certain businesses, mass

transit, schools, and daycare centers. Employees may need to have flexible schedules or to work remotely because of these limitations.

Develop and implement a plan for maintaining a safe, healthy, diverse and inclusive workplace in 2022 after reviewing local pandemic conditions and all relevant guidance. Consider these steps:

- Decide whether to encourage or mandate vaccines. Develop plans on how to request information about employees' vaccinations or provide vaccines on site. Comply with applicable state or local laws requiring paid leave for employees to get vaccines and recover from any side effects, and consider whether to voluntarily offer this leave in other locations.

- Review modifications to physical workspaces (e.g., social distancing and restricted use of common spaces), hygiene practices (e.g., cleaning and disinfecting), health and other employee benefit plans, paid and unpaid leave policies, flexible work schedules, technology, and the overall size of the workforce or the number of workers on site at any particular time (create cohorts of workers). Frequently revisit the ongoing necessity and efficacy of these changes. Continue to review pandemic conditions and guidelines (including guidelines for fully vaccinated workers) that may require additional changes.

- Consider screening or testing employees for COVID-19 while complying with confidentiality requirements, and prepare to respond if or when an employee is symptomatic or tests positive.

  - Federal law requires coverage of medically appropriate COVID-19 testing without cost sharing when the test is conducted for individualized diagnosis or treatment. However, agency guidance confirms this mandate does not apply to COVID-19 screening for other purposes, such as general workplace health and safety or public health surveillance. As a result, group health plans don't have to pay for return-to-work testing. However, self-funded employer plans probably can cover COVID-19 testing for return-to-work purposes, and state laws may require insured plans to cover testing for certain workforces (e.g., healthcare or nursing home staff).

  - Do not conduct or require antibody testing of employees as a precondition for returning to an on-site workplace; ADA does not permit this type of testing.

- Continue with plans for managing an employee who shows symptoms or tests positive for COVID-19, including contact tracing and quarantining co-workers who may have been exposed.

- Consider whether to require fully vaccinated employees to wear face masks or use other PPE, if necessary.

- Consider whether and when to resume some business travel to meet with clients, customers and colleagues in person rather than through virtual meetings.

- Review issues for remote workers, including tax and other compliance issues, cybersecurity protocols, and other technology matters. Consider a hybrid workspace.

- Review practices to support remote workers (including issues like video conferencing and childcare) and accommodate employees whose disabilities create high risk for COVID-19.

Develop contingency plans, debrief often and decide whether to correct course as conditions change. Prepare continuity plans for future outbreaks.

Related resources

3

Transparency for group health plans, insurers and hospitals

Action

Prepare to comply with the final transparency in coverage rule for group health plans and insurers. Get ready to post machine-readable files in 2022 with in-network provider rates and out-of-network allowed payments. Watch for additional guidance on transparency requirements, but prepare to make good-faith efforts to comply with many of the CAA's transparency requirements in the interim, generally starting with plan years beginning on or after January 2022. Work with vendors to ensure compliance, as plan sponsors typically don't have the required information for the new disclosures. Review the hospital prices — including negotiated rates — made public in 2021 under the final transparency regulation for hospitals.

Specific steps

Review the final transparency rule for group health plans and insurers and the agencies' subsequent enforcement relief, and prepare to comply beginning in 2022. Determine which plan service providers will supply required data for the disclosures and how. Decide where to post machine-readable files on a public website and how to handle monthly updates. Consider working with a transparency vendor to assist with the machine-readable files and self-service transparency tool. Decide whether to include both price information and quality metrics in the self-service tool. Verify that vendors will comply with all new requirements that apply. Communicate changes to plan participants, and update language in the plan document and SPD as necessary.

- **Examine how the transparency rule will affect your group health plan and its participants.** The transparency rule doesn't apply to grandfathered plans, HRAs, excepted benefits, expatriate plans exempt from ACA provisions, retiree-only plans or short-term limited-duration insurance. The rule requires other group health plans, including self-funded plans and health insurance issuers, to take two key actions:

  — Make machine-readable files available on a public website, starting with plan years beginning on or after January 2022, subject to the enforcement delays described below. The final transparency rule requires standardized machine-readable files, updated monthly, containing the plan's negotiated rates for in-network providers, past allowed payments to out-of-network providers and prescription drug information. Regulators intend this requirement to facilitate price comparison and consumer-oriented innovation in the healthcare market.

  - The final transparency rules require posting machine-readable files related to in-network rates and out-of-network allowed amounts and billed charges for plan years beginning on or after January 1, 2022, but the departments will defer enforcement until July 1, 2022. Plans with plan years beginning after July 1, 2022 must post files by the first day of the 2022 plan year.

  - Enforcement related to posting machine-readable files with prescription drug prices has been delayed pending further rulemaking, as the agencies determine whether this requirement remains appropriate in light of the reporting on pharmacy benefits and drug costs mandated by the CAA (described below).

— **Provide a self-service cost transparency tool for 500 covered services and items for plan years beginning on or after January 2023, and for all covered services and items by the 2024 plan year.** (Note that the CAA also requires a price comparison tool for which enforcement has been delayed until January 2023, as discussed later.) This internet-based self-service tool must:

  - Disclose personalized out-of-pocket costs for all covered healthcare items and services (with paper copies available on request)

  - Give participants an estimate of their cost-sharing liability for any in- or out of-network provider, allowing them to compare costs before receiving medical care

  - Enable searching by billing code, descriptive terms, in-network provider name and other relevant factors (such as geography)

  - Track a participant's accruals toward any cumulative treatment limitations (like day or visit limits) as well as deductibles and out-of-pocket maximums

- **Review impact on potential MLR rebates (insured plans only).** To encourage consumers to shop for better prices, the rule allows insurers to reduce MLR rebates if insured plans share cost savings with enrollees who choose less-expensive providers.

- **Avoid potential penalties.** Group health plans failing to meet the new transparency rules could face steep penalties of $100/day per participant. However, many group health plan sponsors don't have access to all negotiated prices and can't provide the transparency disclosures without input from the plan's insurer or TPA. The rule offers some relief to sponsors in this situation:

  — A safe harbor spares an employer with a fully insured group health plan from having to provide the transparency disclosures to participants, as long as a written agreement requires the insurer to do so. If the insurer fails to provide the required information, the insurer — not the group health plan — will face liability for the violation. So employers with insured plans should ensure that their carriers provide such a written agreement.

  — The rules also provide relief for group health plans that act in good faith and with reasonable diligence to provide the disclosures, but make an error or omission or are unable to obtain

complete or accurate information from another entity. Group health plans likewise won't face penalties if the website hosting the transparency tool and files is temporarily inaccessible. In both cases, the plan must correct the problem as soon as practicable. Employers should understand how group health plan vendors are going to assist with compliance and update contracts as necessary. Consider negotiating performance guarantees related to transparency compliance.

Review the CAA's transparency requirements and the agencies' enforcement relief. Prepare to make good-faith efforts to comply until regulations come out. Look for additional triagency guidance on several CAA transparency topics in 2021 and 2022. The CAA's new requirements, which, unless otherwise noted, generally take effect for plan years starting on or after Jan. 1, 2022, include:

- **Price comparison tool.** The tool must be available by telephone and on the plan or issuer's internet website. To the extent practicable, the tool must allow a participant to compare the amount of cost sharing that they will be responsible for paying under the plan for a specific item or service from participating providers in a particular plan year and geographic region. Note that the effective date for the CAA price comparison tool is a year earlier than required for the cost transparency tool under the transparency regulation. Regulators are delaying enforcement of the CAA's price comparison tool requirements for plan years beginning before Jan. 1, 2023, to align with the enforcement of the self-service cost transparency tool in the final transparency rules (discussed above).

- **Prescription drug reporting (deadline postponed pending guidance, but plans should prepare to report 2020 and 2021 data by Dec. 27, 2022).** Federal regulators have asked for comments on various prescription drug reporting requirements, and additional guidance is expected. In the interim, group health plans should make good-faith efforts to comply with the law. The CAA requires that group health plans report to federal regulators extensive prescription drug data for the prior plan year, including:

  - States where the plan is offered
  - Number of participants and beneficiaries
  - Top 50 brand drugs most frequently dispensed and number of claims
  - Top 50 most costly drugs and amount spent for each
  - Top 50 drugs with greatest increase in expenditures over the plan year and the amount expended by the plan
  - Total spending on healthcare by plan type
  - Average monthly premium paid by the employer and employees

  - Premium impact of rebates paid to plan, including amounts paid for each therapeutic class of drugs and the 25 drugs with the highest rebates
  - Any reduction in premiums and out-of-pocket costs associated with these rebates

- **Advance EOBs.** Healthcare providers and facilities will have to provide group health plans a good-faith estimate of expected charges when an enrollee expects to submit a claim for a specific item or service. A group health plan that receives such a notification or a request from a participant has to meet tight time frames to provide the participant an advance EOB with detailed information about the plan's coverage of the scheduled item or service. The agencies are delaying enforcement of this provision pending publication of regulatory guidance, which is not anticipated before Jan. 1, 2022.

- **Disclosures on health plan ID cards.** Physical or electronic health plan ID cards must include any applicable deductible or out-of-pocket maximum, along with a telephone number and internet website address for obtaining consumer assistance, such as information on hospitals and urgent care facilities that have a contractual relationship for furnishing items and services under the plan. Regulators expect good faith compliance until regulations are issued.

- **Up-to-date provider directories.** Group health plans must provide an accurate, verified database on their public website that contains a list of and directory information on each healthcare provider and healthcare facility with a direct or indirect contractual relationship with the plan. Group health plans also must prepare to respond to participant questions about the provider directory. If this database incorrectly lists an out-of-network provider as in-network and a participant or beneficiary obtains items or services from that provider, the plan must limit cost sharing to the in-network amount and credit those amounts toward the in-network deductible or out-of-pocket maximum. Regulators expect good faith compliance until regulations are issued.

- **Broker and consultant disclosures.** Brokers and consultants expecting to receive at least $1,000 for their services will have to disclose to group health plans all direct and indirect compensation for those services.

- **Ban on gag clauses that prohibit sharing price and quality information (effective Dec. 27, 2020).** Plan sponsors will need to attest that none of their plan-related contracts has such a gag clause. Regulators intend to issue additional guidance about how attestations should be submitted, and anticipate beginning to collect attestations starting in 2022.

Review the final hospital transparency rule to understand what rates hospitals have to disclose in 2021. Work with relevant experts — e.g., data specialists, clinicians, etc. — to understand the hospital data. Look for additional hospital disclosures as enforcement against noncompliant hospitals increases.

- **Examine how newly disclosed information might help plan participants.** Hospitals had to make several disclosures by Jan. 1, 2021, but compliance has apparently been spotty. A recent

executive order calls for HHS to support existing price transparency initiatives for hospitals (as well as for other providers and insurers). Here are the hospital disclosures currently required:

  - **Consumer-friendly disclosure.** Hospitals must provide payer-specific negotiated charges, discounted cash prices, and deidentified minimum and maximum negotiated charges — the lowest and highest negotiated average price at the hospital — for 300 shoppable services. This information must be displayed and packaged in a "consumer-friendly" manner (which can be met by using a price-estimator tool). Of the 300 shoppable services, CMS selected 70, and the hospital could choose the remainder.

  - **Publicly available, machine-readable files.** Each hospital must make available to the public machine-readable files that contain gross charges, payer-specific negotiated charges, discounted cash prices, and deidentified minimum and maximum negotiated charges for each item and service the hospital provides. The payer-specific negotiated charge is the charge for an item or service that a hospital has negotiated with an insurer or a TPA — or in some cases, directly with a plan or plan sponsor.

- **Explore new opportunities to negotiate or directly contract rates with individual hospitals or hospital systems if a particular plan currently pays higher rates than what other entities pay.** The hospital data should provide unprecedented insights into the rates that participants and plans pay for medical services and items like prescription drugs at hospitals. Providers and PBMs generally have treated negotiated rates as proprietary information inaccessible to plan sponsors. The transparency rules could infuse more competition into the healthcare marketplace, allowing plan sponsors to negotiate better rates while giving participants upfront estimates of medical expenses at different providers.

- **Look for more robust disclosures from hospitals as enforcement efforts increase.** Not all hospitals have fully complied with the transparency rules. But employers and participants' efforts to use hospital disclosures may be aided by CMS's efforts to increase enforcement. CMS recently proposed rules that would increase penalties for noncompliance (currently $300 per day) to a maximum total penalty of about $2 million per year.

Consider commenting on proposed rules, and watch for more guidance. CMS clarified in proposed rules that hospitals can't create barriers to access the machine-readable files — the files must be accessible to automated searches and direct downloads. The agency also clarified the outputs for a price-estimator tool that can be used as the consumer-friendly disclosure. Hospitals can use an online price-estimator tool that takes an individual's insurance information into account. The estimate must reflect the amount the hospital anticipates the individual will pay for the shoppable service, absent unusual or unforeseeable circumstances. CMS is also asking for comments on the hospital transparency rules, such as:

- Best practices for online price estimator tools to incorporate

- Standards for "plain language" descriptions of shoppable services

- Methods to identify and highlight exemplar hospitals
- Improvements to the standardization of the machine-readable files

Related resources

4

Surprise billing

Action

Confirm plan administrators are prepared to comply with the ban on surprise billing for emergency services, air ambulances and certain nonemergency services covered by the No Surprises Act for the first plan year starting on or after Jan. 1, 2022. Prepare for increased costs associated with compliance, post the required notice about surprise billing on a public website, consider developing additional communications for plan participants and amend plan documents as needed.

Specific steps

Confirm plan administrators are prepared to comply with the prohibition on surprise billing if the plan covers services protected by the No Surprises Act. Beginning Jan. 1, 2022, patients are protected from unexpected or "surprise" medical bills for (i) emergency care (including ancillary services) received at an out-of-network facility or at an in-network facility from an out-of-network provider; (ii) out-of-network nonemergency services at an in-network healthcare facility (unless written consent obtained); and (iii) air ambulance services from out-of-network providers.

- Determine which plans are subject to the surprise billing rules.
  - The ban applies broadly to grandfathered and nongrandfathered group health plans, as well as federal and nonfederal governmental plans, certain church plans, so-called "grandmothered" or transitional plans, and individual policies (including student health insurance).
  - The ban doesn't apply to excepted benefits, retiree-only plans, short-term limited-duration insurance, or HRAs and other account-based plans.
- Confirm that plan administrators are prepared to calculate the permissible cost-sharing amounts for these protected services in compliance with the law and rules.
  - Plan participants can only be charged what they would pay for these protected services in network, and the cost sharing must count toward any in-network deductible or out-of-pocket maximum.
  - Cost sharing is based on the *recognized amount*, which usually will be the lesser of either the billed charge or the *qualifying payment amount*, which is generally the plan's or issuer's median contracted rate.

  - When a state law determines the recognized amount, an insured plan must follow the state law to determine the allowed cost-sharing amount.

  - If an all-payer model agreement (APMA) covers the item or service at issue, then the cost-sharing amount (and the provider reimbursement) is based on the amount recognized by the APMA. An APMA is an agreement between CMS and a state to test and operate systems of all-payer payment reform.

- The *qualifying payment amount* is the plan's or issuer's median contracted rate as of Jan. 1, 2019, for similar services in the geographic area, adjusted by percentage increases in the Consumer Price Index for All Urban Consumers (CPI-U). Value-based payments or adjustments are excluded. The interim final rule (Part I) provides details on how to determine the qualifying payment amount.

  - *Self-insured plans* can determine the *median contract rate* using either all of the employer's self-insured group health plans or all self-insured plans administered by the plan's TPA.

  - *Issuers* of large group health plans determine the *median contract rate* across all large group plans offered by that issuer.

- Check that plan administrators are prepared to calculate out-of-network providers' and facilities' *initial payment amount* for these protected services in compliance with the law and rules. The initial payment should be the full payment, including any cost sharing. Plans have only 30 days from the time a bill is received to send the initial payment with required disclosures or a notice of denial.

  - In most cases, the initial payment will be an amount agreed to by the plan or issuer and the provider or facility, unless a state law or an APMA determines the reimbursement amount.

    - When determined by the plan or issuer, the initial payment amount should be an amount reasonably determined to be payment in full, based on the relevant facts and circumstances and as required under the terms of the plan or coverage.

  - Disclosures to out-of-network providers sent with the initial payment amount (or the notice of claim denial) must include a certification of compliance with the qualifying payment amount regulations. The disclosure also must include a statement that the provider can request a 30-day open negotiation period, followed by independent dispute resolution (IDR), and contact information for the provider to initiate open negotiation.

  - Plan administrators will need to comply with the IDR process required by the federal law and rules when no state law applies and the parties cannot agree upon a reimbursement amount.

- For self-insured plans, consider whether to opt into state laws regulating balance-billing.

  - Self-insured plans can voluntarily comply with a state law that provides a method for determining cost sharing and the total amount payable, if the law allows opt-ins (e.g., Maine, Nevada, New Jersey, Virginia and Washington).

  - If opting into a state program, the plan must comply with the state law for all covered items and services, as well as federal law for any items and services not covered by the state law.

- Consider including performance guarantees related to compliance with the surprise billing law and rules in carrier policies and TPA contracts.

  - Performance guarantees could involve meeting deadlines set out in the law and rules, accurately determining the qualifying payment amount and the associated participant cost sharing using the methods prescribed by the agencies, appropriately accumulating cost sharing toward deductibles and out-of-pocket costs, etc.

Amend plan documents (including SPDs and SBCs) to align with coverage requirements for plans beginning on or after Jan. 1, 2022. The ACA has imposed certain standards on nongrandfathered plans that cover hospital-based emergency services since Sept. 23, 2010. The No Surprises Act expands on these coverage standards and applies them to both grandfathered and nongrandfathered plans.

- Confirm coverage of emergency services without prior authorization, regardless of whether a provider or facility is in-network. Confirm cost sharing for emergency services counts toward in-network deductibles and out-of-pocket maximums.

  - Emergency services include services in a hospital's emergency department (including routine ancillary services needed for evaluation) or an independent free-standing emergency department, as well as certain post-stabilization services. Urgent care centers are also included if licensed by the state to provide emergency care.

  - Confirm coverage of post-stabilization services as emergency services (including outpatient observation, or an inpatient or outpatient stay if provided with the other emergency services), regardless of where the services are furnished in the hospital, unless all conditions outlined in the interim final rule (Part I) rule are met. Among those conditions, (i) the individual can travel to an available in-network provider located within a reasonable distance using nonmedical or nonemergency transportation; (ii) the individual gives informed consent for the out-of-network care and agrees to balance billing after proper notice; and (iii) any other state or federal law requirements that apply.

  - Confirm the plan does not limit coverage based on plan terms or conditions (other than the exclusion or coordination of benefits) and does not impose more restrictive administrative requirements or benefit limitations on out-of-network providers than those applied to in-network emergency service providers.

    - The interim final rule (Part I) clarifies that plans cannot deny emergency services based on general plan exclusions. For example, a plan cannot deny claims for emergency services provided to a pregnant dependent based on a general plan exclusion for dependent maternity care. Plans cannot deny coverage based solely on a diagnostic code or without first applying the "prudent layperson" standard. Plans cannot deny coverage because some

time passed between when symptoms began and when emergency care was sought or because the symptoms did not come on suddenly.

- Confirm cost sharing for out-of-network nonemergency services provided without written consent at an in-network healthcare facility and out-of-network air ambulance services is limited to in-network amounts and accumulates toward in-network deductibles and out-of-pocket maximums.
  - An in-network or participating healthcare facility is one with a direct or indirect contractual relationship with a group health plan or issuer. This includes a hospital, hospital outpatient center, critical access hospital and ambulatory surgical center. Urgent care centers and retail clinics are not considered healthcare facilities subject to the protection from surprise bills for nonemergency services provided by out-of-network providers at an in-network healthcare facility. But this could change based on comments about the interim final rule (Part I).
  - The cost-sharing limitations apply to items and services provided during a visit to an in-network facility, including equipment and devices, telemedicine, imaging and laboratory services, and pre- and post-operative services, even if the provider furnishing the service is not at the facility. For example, a lab sample collected at an in-network facility sent off site to an out-of-network laboratory for analysis would be covered as part of the visit to the in-network facility if the plan covers laboratory services.
  - The cost-sharing limitations apply to air ambulance services if the group health plan covers those benefits, even if it has no in-network providers.

Prepare to comply with notice requirements for group health plans and issuers, and consider developing other employee communications.

- Prepare to post on a public website information, written in plain language, about balance-billing restrictions, applicable state law protections, the federal protections, and contact information for an appropriate state and federal agency in the event a provider or facility violates the balance-billing restrictions.
  - Use of the agencies' model notice will demonstrate good-faith compliance, but plans and issuers can develop their own notices.
- Confirm the plan administrator is prepared to include in each EOB the same information about the balance-billing protections for an item or service covered by the No Surprises Act.
  - If a state with balance-billing protections has a model notice, plans and issuers can use the state's model language to provide the required information about the applicable state law protections.

Prepare to answer questions from plan participants about balance bills. Employers may want to develop a process for responding to or redirecting employee inquiries. Vendors may develop services

for assisting plan participants who receive — or think they have received — impermissible balance bills.

- Out-of-network emergency providers, air ambulance providers and out-of-network providers furnishing certain nonemergency services at in-network healthcare facilities, including hospitals and ambulatory surgical centers, are prohibited from balance-billing patients.
  - Plan participants only have to pay applicable in-network cost sharing (copayments, coinsurance and deductibles) in these circumstances. The health plan pays the facility and out-of-network providers directly.
- Balance-billing may be permitted for certain out-of-network nonemergency services provided at an in-network healthcare facility if the patient gives consent after receiving an advance written notice that complies with the law and rules. However, consent cannot be given if the healthcare facility doesn't have an in-network provider available.
  - Balance-billing is never permitted for anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services provided at in-network facilities by out-of-network providers.
- Balance-billing is permitted for nonemergency services provided by out-of-network providers and facilities not covered by the No Surprises Act, like outpatient mental health providers and services delivered in a physician's office.

For insured plans, work with carriers to understand if any state balance-billing laws — or portions thereof — apply instead of or in addition to the federal law. In the No Surprises Act, Congress deferred to some state laws and limited the degree to which the federal law preempts state law (see State activity).

- State surprise-billing laws are not summarily preempted by the federal law. They can have standards more protective of consumers than the federal law, but cannot impose requirements that undermine or prevent the operation of the federal law.
  - At least 33 states have enacted balance-billing protections. At least 18 of these laws are comprehensive, according to the Center on Health Insurance Reforms.
  - The state laws vary widely. For example, some apply only to emergency situations or certain types of health insurance plans, while some include a payment standard or IDR process.
- The federal law specifically defers to state laws governing the methods for determining payments to out-of-network providers.
  - State laws that set a payment standard, require a dispute resolution process or use a hybrid of both approaches are not preempted.

  - The state law also controls the amount of cost sharing a patient must pay for protected out-of-network services.

- If a state law does not cover certain providers or facilities that are covered by the No Surprises Act, disputes with those providers or facilities are resolved under the federal process. The same approach applies for services not covered under a state law.

Watch for additional regulations and agency guidance on the balance-billing ban and other provisions of the No Surprise Act.

- Part I of the interim final rule is open to comments until Sept. 7. The agencies are seeking comments on a large range of issues, including (i) the possibility of setting a minimum payment rate or methodology for a minimum initial payment; (ii) the method of determining the qualifying payment amount; (iii) alternative approaches to calculating the cost-sharing amount for out-of-network air ambulance services; (iv) plan disclosure requirements; and (v) the need for any other plans to be exempt from some or all of the surprise billing rules.

  - Employers should watch for any updates, corrections or amendments to the rule in response to comments submitted.

- More guidance on plan and issuer notices and disclosures about surprise billing may be published.

- Treasury and IRS guidance on using the annual CPI-U increase when determining the qualified payment amount is expected soon.

- Regulations establishing an audit process for qualified payment amounts are due by Oct. 1.

- Guidance on the IDR process is due by Dec. 27, but may come as soon as August.

- A later rule is expected to address enforcement.

- The agencies have to develop a complaint process for consumers improperly balance-billed and for violations by plans and insurers.

- Guidance on other provisions of the No Surprises Act — including required information for health plan ID cards, provider directory requirements, and continuity-of-care protections — will not be issued until after Jan. 1, 2022.

  - In the interim, plans still must comply in good faith with these provisions. (For more information on these and other transparency requirements in the CAA, see Transparency for group health plans, insurers and hospitals.)

Related resources

5

Gender and family planning issues in benefits

Action

Consider whether benefit changes are required for LBGTQ employees and their family members as a result of the Supreme Court's 2020 *Bostock* decision, ACA Section 1557, MHPAEA or state laws. Employers considering enhanced fertility, adoption and surrogacy benefit programs to support DEI goals and the needs of a diverse workforce should consider compliance issues, including federal tax, ACA and state laws.

Specific steps

Review benefit eligibility and other plan terms for discrimination in light of the Supreme Court's *Bostock* decision, which found Title VII of the 1964 Civil Rights Act protects LGBTQ employees. Also consider any state nondiscrimination laws or other state laws protecting the LGBTQ community (including insurance mandates).

- Confirm benefits offered to opposite-sex spouses are also offered to same-sex spouses. If offering domestic partner coverage, confirm benefits are offered to both same-sex and opposite-sex domestic partners. If not all spouses and domestic partners are offered benefits, review risk under applicable laws.
- Review group health plan terms excluding or limiting coverage for gender dysphoria or related services for risk under Title VII or state laws.
- Review gender identity categories used in benefit administration, and consider options for more inclusive descriptors. Ensure transgender enrollees are covered for provider-approved preventive care, regardless of the individual's sex assigned at birth, gender identity or recorded gender.
- Review the disability plan to confirm coverage for temporary disabilities due to gender-affirmation surgeries.

Consider whether ACA Section 1557's ban on sex discrimination requires offering transgender coverage. Monitor litigation about the applicability and requirements of Section 1557.

- Determine whether Section 1557 applies to any group health plan. The scope of Section 1557 remains uncertain, since at least one court has rejected the 2020 final regulations' narrow application of the law (*Fain v. Crouch*, No. 3:20-0740 (S.D. W. Va. June. 28, 2021)).
  - Employers and group health plans directly receiving federal funds, as well as self-insured plans using a TPA or PBM that receives federal funds, should monitor this litigation and regulatory developments.
- If Section 1557 applies, review the plan's transgender coverage for impermissible exclusions or limits.
  - At least two courts have rejected the 2020 final regulations' removal of transgender protections (*Whitman-Walker Clinic v. HHS*, No. 20-1630 (D.D.C. Sept. 2, 2020) and *Walker v. Azar*, No. 20-2834 (E.D.N.Y. Aug. 17, 2020)). In addition, HHS this year announced it would interpret and enforce Section 1557 to prohibit discrimination based on sexual orientation and gender identity.

Review any exclusions or limits on the plan's coverage of gender dysphoria treatment and services (including gender affirmation surgery) for compliance with MHPAEA and any applicable state parity laws.

- Examine any blanket exclusion of transgender services or denial of claims for transgender services regardless of medical necessity. Such exclusions or denials are likely NQTLs on a mental health condition that should be analyzed for parity with medical/surgical benefits (see the Mental health parity section).
- Consider any applicable state laws, such as California's recent legislation expanding mental health parity requirements for insured plans effective Jan. 1, 2021 (see the State activity section).

Review the group health plan's provider network for adequate access to providers supportive of and knowledgeable about LGBTQ healthcare.

- Review provider networks to ensure reasonable access to providers experienced with gender dysphoria. Consider advocacy on behalf of LGBTQ employees in response to state efforts to restrict available healthcare.

For churches and employers with religious objections to covering same-sex spouses or gender dysphoria, consult legal counsel about the risks of these exclusions and potential exemptions. Monitor litigation over religious exemptions to Title VII and ACA Section 1557.

Keep compliance issues in mind when expanding fertility benefits. Fertility benefits have historically targeted heterosexual married couples unable to conceive after a specified period of time

following unprotected intercourse or due to medical treatments (such as cancer treatments). Many employers are now seeking to expand fertility benefits to employees beyond a diagnosis of infertility and regardless of marital status, gender, and sexual orientation.

- **Consider tax implications of expanding fertility coverage.** Work with legal counsel, tax advisor and vendors to determine whether and how to tax employees for fertility benefits. Fertility benefits can be excluded from an employee's taxable income only if considered medical care, defined as "for the diagnosis, cure, mitigation, treatment or prevention of disease," or "for the purpose of affecting any structure or function of the body." IRS hasn't issued guidance addressing when fertility treatments are medical care. The few reported decisions — involving male taxpayers trying to conceive — have found expenses related to egg donation, *in vitro* fertilization (IVF) and freezing are not tax-deductible. However, an IRS private letter ruling allowed the deduction for sperm donation and freezing costs directly attributable to the taxpayer, but the ruling only applies to the person who requested it. IRS has not opined on the taxation of fertility benefits in other contexts, such as a female employee freezing her eggs to preserve future fertility.

- **Assess tax implications of covering tissue storage.** Consult a tax advisor if adding coverage for the storage of eggs, sperm or embryos. Even for employees with an infertility diagnosis, IRS Publication 502 indicates that "temporary" storage is tax-preferred, but does not identify the point at which storage costs become taxable.

- **Keep in mind ACA's prohibition on annual and lifetime dollar limits.** Ensure compliance with ACA's ban on annual or lifetime dollar limits for EHBs. Self-insured plan sponsors should remove dollar limits on fertility benefits or confirm that fertility benefits aren't considered EHBs under the selected state benchmark plan. Consider cycle limits as an alternative.

- **Integrate fertility benefits with the medical plan.** Limit fertility benefits to medical plan enrollees, or discuss the risks of a stand-alone fertility benefit program with counsel. A stand-alone fertility benefit program is a group health plan that would likely violate ACA mandates (for example, by not covering preventive services without cost sharing).

- **Consider HSA/HRA issues.** Ensure that fertility coverage doesn't cause an individual to lose eligibility to make or receive contributions to an HSA. For example, an HRA that pays for fertility treatments before an individual reaches the HDHP deductible would be HSA-disqualifying coverage. An HRA should only reimburse those fertility expenses that are medical care as defined by the Internal Revenue Code, but — as explained above — that can be a difficult determination.

Consider compliance issues in implementing and administering a surrogacy benefit program.

- **Work with a tax advisor to ensure that employees are taxed correctly on surrogacy benefits.** Favorable tax treatment may be available for a limited set of surrogacy expenses — namely, medical expenses for an employee or an employee's spouse diagnosed as infertile. Other surrogacy benefits are taxable income.

- **Draft surrogacy program with counsel.** Carefully consider what expenses will be reimbursed. Reimbursing a surrogate's medical expenses may cause compliance problems, such as by

possibly creating an ERISA-covered group health plan that does not satisfy ACA mandates (for example, coverage of the surrogate's ACA-mandated preventive services without cost sharing). Reimbursement of a surrogate's medical expenses also could create rights that the surrogate could enforce against the plan. Limiting reimbursements to taxable, nonmedical expenses (e.g., legal and agency fees) would avoid these compliance problems.

Check for any international or state prohibitions.

- Ensure that neither fertility nor surrogacy expenses are reimbursed in violation of any international or state law, such as laws prohibiting egg freezing or commercial surrogacy.
- Monitor changes in applicable law, such as New York's law allowing paid surrogacy agreements as of Feb. 15, 2021.
- Obtain the services of legal counsel or a vendor to assist with tracking relevant laws and determining whether particular expenses violate international or state law.

Review compliance considerations for adoption benefit programs.

- Up to $14,440 (for 2021) of qualifying adoption expenses per eligible child may be excluded from an employee's income (less for high-income employees), if paid by an adoption assistance program satisfying IRC Section 137.
  - Section 137 requires a written plan document, employee notice and compliance with nondiscrimination rules.
  - Section 137 does not permit reimbursements to pay for surrogacy arrangements, adoption of a stepchild, or expenses in violation of a state or federal law.
- If providing adoption benefits beyond what Section 137 permits, work with a tax advisor to make sure that employees are taxed appropriately.

Work with counsel and payroll to properly implement after-tax fertility, adoption or surrogacy benefits.

- Consult with employment counsel and payroll to determine whether the taxable reimbursements increase hourly wages for overtime, vacation and other employment-related purposes.
- Consult a tax advisor or legal counsel about whether to "gross up" employees for withheld taxes and how to ensure compliance with deferred compensation rules.

Related resources

6

Mental health parity

Action

Ensure the plan has prepared the NQTL comparative analysis required by the 2021 CAA. If not in full compliance, consider strategic interim steps while working toward full compliance. Prepare a response plan to react immediately to a request from federal agencies for the NQTL comparative analysis. Include assistance with NQTL comparative analyses in any future RFPs and vendor contracts. Watch for additional guidance and litigation in 2022.

Specific steps

Continue to comply with MHPAEA.

- Ensure covered mental health and substance use disorder (MH/SUD) benefits are in parity with covered medical/surgical benefits and do not impose financial requirements or treatment limitations (quantitative and nonquantitative) that are more restrictive for MH/SUD benefits than for the same classification of medical/surgical benefits. MHPAEA applies to grandfathered and nongrandfathered insured and self-insured group health plans that are not excepted benefits, including state and local government plans (except self-insured government plans that have opted out).

Confirm the plan has completed the NQTL comparative analysis required by the CAA.

- **Keep in mind that federal agencies have already begun asking group health plans and insurers to produce a comparative analysis of their design and application of all NQTLs.** In addition, DOL and CMS each must request at least 20 comparative analyses per year. Plan participants, beneficiaries, enrollees and their authorized representatives may also request the comparative analysis.

- **Verify that the carrier for an insured plan has completed the analysis and will notify the employer if a federal or state authority finds a parity violation.** Confirm that the insurer will respond to any requests for the NQTL comparative analysis, whether the request is from CMS, a state authority, or a plan participant, beneficiary or enrollee. Verify that the insurer complies with applicable state mental health parity laws, including any reporting requirements (see State activity section).

- **For any self-insured plan sponsor that has yet to complete an NQTL comparative analysis, prepare one as soon as possible.**
  - Contact relevant TPAs *as soon as possible* to establish what level of support each will provide. Remember to contact the PBM if prescription drugs are administered separately.
  - Ask whether the TPA will produce a CAA-compliant comparative analysis for all NQTLs that are standard across the plans administered by the TPA. For example, prior-authorization criteria may be standardized across plans administered by the TPA, so the same comparative analysis should apply to many of those plans.
  - Ask for a list of nonstandard NQTLs applied to the employer's plan — that is, any nonnumerical limitations or exclusions of MH/SUD treatment in the customized plan design. Determine whether the TPA will assist in preparing the comparative analysis for nonstandard NQTLs. Retain outside assistance — e.g., from legal counsel and clinical experts — to help prepare a comparative analysis for nonstandard NQTLs.
  - Ask for a time frame in which the TPA expects to assist with the comparative analysis. Remember that many employers have been making similar requests of TPAs.
  - Review current vendor contract for terms that may obligate the TPA to assist with the comparative analysis.
  - If plan has behavioral health carve-out with a separate vendor, consider seeking outside assistance — e.g., from legal counsel and clinical experts. The comparative analysis of each NQTL will require demonstrating that the processes, strategies, evidentiary standards and other factors used by *the behavioral health vendor* to apply the NQTL to MH/SUD benefits (in written terms and plan operations) are "comparable to and applied no more stringently" than those used by *the medical TPA* to apply NQTLs to medical/surgical benefits. Analyzing and comparing the information provided by different vendors for parity can be challenging and will likely require expertise.

Check that the completed NQTL comparative analysis has all required elements.

- Be ready to produce the following information on request, as required by the CAA:
  - Specific plan or coverage terms regarding NQTLs and a description of all MH/SUD and medical/surgical benefits to which each term applies, including which of the six parity classifications (i.e., inpatient in-network, outpatient in-network, pharmacy, etc.) contains the benefit
  - Factors used to determine that the NQTLs should apply to the benefits
  - Evidentiary standards and other sources on which the plan relied to back up the factors used to design the NQTL and justify its application to a benefit

  - Comparative analysis of each NQTL for benefits in each classification "demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the NQTLs" to MH/SUD benefits (in written terms and plan operations) are "comparable to and applied no more stringently" than those used to apply NQTLs to medical/surgical benefits

  - Results of the comparative analysis, including specific findings and conclusions on what is and is not in compliance with the parity law

- Review the nine data elements required for each NQTL in FAQs Part 45 (FAQ 2).

- Consider obtaining a review by in-house or outside counsel to confirm compliance with the elements of the CAA comparative analysis.

While working toward full CAA compliance, consider some or all of the interim steps listed below to potentially reduce the risk of noncompliance.

- Prepare to respond to any participant requests for information within 30 days, in accordance with 2019 guidance. Since DOL may select plans to audit because of participant complaints, responding to participant requests for information is critically important.

- Review the 2020 MHPAEA self-compliance tool. According to DOL, plans that carefully apply the guidance in the 2020 self-compliance tool are well-positioned to meet the CAA's standards for the comparative analysis.

- Focus on NQTLs identified by the DOL (see FAQ 8) as enforcement priorities:

  - Prior-authorization requirements for in-network and out-of-network inpatient services

  - Concurrent review for in-network and out-of-network inpatient and outpatient services

  - Provider-admission standards, including reimbursement rates, for network participation

  - Out-of-network reimbursement rates (the plan's method for determining usual, customary and reasonable charges)

- Identify other red-flag NQTLs that may be present in plan documents.

  - Look for NQTLs that have generated litigation. Examples include limits on applied behavioral analysis (ABA) therapy for autism, wilderness therapy, treatments for eating disorders or residential treatment for substance abuse.

- Look for examples of NQTLs flagged in agency guidance.

  - For instance, FAQs on the CAA's parity provisions (FAQ 8) give an example of a complaint about prior authorization to use buprenorphine to treat opioid use disorders.

- Consider an interim strategy to address some or all of the red-flag NQTLs and the NQTLs identified as agency enforcement priorities. Weigh whether simply removing any of those limits on MH/SUD treatments is a cost-effective strategy. If not, consider expediting a comparative analysis of these NQTLs.

- Develop a written compliance plan to promote "the prevention, detection and resolution of potential MHPAEA violations," as recommended in DOL's MHPAEA self-compliance tool. The written compliance plan could include auditing claim denials and appeals for MH/SUD treatments and prescription drugs, and establishing internal protocols to ensure vendors provide the documentation needed to assess parity compliance.

Prepare a response plan to react immediately to a request from a government agency (or an entity acting on its behalf) for an NQTL comparative analysis.

- Know which agency enforces MHPAEA for your plan. DOL enforces MHPAEA compliance by private employers' group health plans, while CMS handles enforcement for nonfederal governmental group health plans. States enforce MHPAEA for insurers, but CMS may take action when a state fails to do so.

- Identify legal counsel to assist in the event of a request from a government agency (or an entity acting on its behalf). Consult counsel about requesting additional time if the NQTL comparative analysis is not complete.

- Prepare for tight time frames. Review correspondence for a deadline to respond. A group health plan has 45 days to specify its corrective actions after DOL's initial finding of a parity violation. Once DOL makes a final determination that a violation has occurred, the plan must notify all enrollees about the noncompliance within seven days of that determination.

Require that future RFPs and vendor contracts include assistance with the NQTL comparative analysis.

- Consider negotiating performance guarantees related to MHPAEA compliance, such as a guarantee of timely responses to disclosure requests from agencies or participants or a guarantee to conduct periodic self-audits for MHPAEA compliance.

Watch for additional guidance in 2022. The CAA requires regulators to issue additional NQTL guidance by July 2022 that includes:

- Examples of prior findings of parity compliance and noncompliance

- Recommendations encouraging the use of internal controls to monitor compliance

- Information about how participants should file complaints to the relevant state, regional or national office

- Examples of methods for determining the “appropriate types” of NQTLs for both MH/SUD and medical/surgical benefits (however, no deadline is specified for issuing this guidance)

Consider MHPAEA when expanding telehealth benefits.

- Before adding low or no-cost telehealth for medical/surgical benefits, consider whether this could cause a plan’s financial limits on MH/SUD benefits to fail MHPAEA testing.

- Evaluate whether adding telehealth options for MH/SUD benefits may help ensure the plan has an adequate network of MH/SUD providers, which may improve MHPAEA compliance while providing a useful benefit to employees and their families.

Keep up with parity and claims litigation. In addition to agency action to enforce parity requirements, private litigation remains a risk.

- Monitor *Wit v. United Behavioral Health*, a class action in which a federal district court ordered a behavioral health administrator for insured and self-insured plans to reprocess more than 67,000 denied claims for services like residential treatment for MH/SUDs. The district court held that the administrator violated ERISA by applying overly narrow clinical guidelines. An appeal is pending before the US Court of Appeals for the 9th Circuit (No. 20-17364).

- Keep in mind that private litigation alleging parity violations for the denial of benefits related to autism, wilderness therapy, treatments for eating disorders or residential treatment for substance abuse can involve the employer plan as well as the TPA.

Related resources

7

HSA, HRA and FSA developments

Action

For 2022, prepare to discontinue changes made by temporary COVID-19 relief, unless future legislation or agency guidance extends or makes the relief permanent. Determine whether to continue (or adopt) the permanent enhancements to account-based plans permitted under the CARES Act and IRS guidance. Adopt Section 125 plan amendments for plan changes reflecting COVID-19 relief; the first amendments are due by Dec. 31, 2021. Update HDHPs and account-based plans for indexed dollar limits. Identify pre- or no-deductible health benefits, programs or point solutions that could jeopardize an individual's eligibility to make or receive HSA contributions, and confirm strategy. Consider whether pending IRS regulations on individual-coverage HRAs or DCPAs will impact benefit strategies and compliance efforts. Review future IRS guidance on medical expenses or the definition of tax dependent for any impact on account-based plans.

Specific steps

Prepare to discontinue changes made by temporary COVID-19 relief. Monitor whether future legislation or regulatory relief extends the time frames below or makes the relief permanent.

- **Stop first-dollar or predeductible telehealth coverage under HSA-qualifying HDHPs by Jan. 1, 2022, for calendar-year plans.** Temporary relief permits HSA-qualifying HDHPs to cover telehealth and remote care services before individuals have met their deductible, without jeopardizing their eligibility to make or receive HSA contributions. This relief expires at the end of the plan year that began in 2021. HDHPs that took advantage of this relief should begin charging participants for any predeductible telehealth services that are not HSA-compatible preventive care. Review whether communications about telehealth coverage clearly indicate that the relief is temporary; if not, prepare additional communications, as discussed in FAQ 13.

- **Administer health FSA and HRA deadlines in accordance with the outbreak period relief.** The Treasury Department and DOL have extended the deadline to file HRA or health FSA claims for up to one year during the COVID-19 "outbreak period." The outbreak period began March 1, 2020, and will end 60 days after the announced end of the COVID-19 national emergency (last extended by President Biden on Feb. 24, 2021). The COVID-19 national emergency is currently set to expire March 1, 2022, unless terminated earlier or further extended.

- Confirm that HRA and health FSA administrators are not extending the claim run-out deadline for more than one year, and participants have been informed about the duration of this extension.

- Watch for any congressional or presidential action to terminate or extend the COVID-19 national emergency.

- Remember that this deadline relief does not apply to dependent care FSAs.

  Example. Peter contributed to a 2020 calendar-year health FSA, which has a 90-day run-out period allowing him to submit claims incurred in 2020 until March 31, 2021. Under the temporary relief, the run-out period for 2020 health FSA claims closes 90 days from the *earlier of* (1) one year after the date Peter was first eligible for relief, or (2) the end of the outbreak period. If the COVID-19 national emergency ends on Sept. 30, 2021, the outbreak period ends 60 days later on Nov. 29, 2021. This means the plan cannot forfeit any remaining balance in Peter's health FSA until Feb. 27, 2022. Alternatively, if the COVID-19 national emergency ends on or after Nov. 2, 2021, the deadline for Peter to file a claim would be March 31, 2022 — 90 days after Dec. 31, 2021 (i.e., one year from the date he was first eligible for the relief).

- **Discontinue any temporary FSA relief permitted by the 2021 CAA or IRS Notice 2021-15.** Some employers may have already discontinued this relief — for example, if an employer allowed midyear FSA election changes during a specific window that has closed. But if any of the following optional relief is ongoing, employers should prepare to end the relief in 2021 or 2022, as applicable:

  - **Midyear election changes.** Midyear changes to FSA elections without a change-in-status event are permitted only through the plan year ending in 2021 (through Dec. 31, 2021, for calendar-year plans).

  - **Uncapped carryovers.** For plan years ending in 2020 and 2021, unlimited carryovers of health and dependent care FSA balances into the next plan year are permitted. Any balance remaining on the last day of the plan year ending in 2022 (Dec. 31, 2022, for calendar-year plans) generally will be forfeited. However, *health FSAs* may permit a carryover of up to $550 (annually indexed), or *both types of FSAs* may allow a 2-1/2 month grace period after the plan year ending in 2022 (e.g., through March 15, 2023, for a calendar plan year). During that 2-1/2 month period, the balance can be used for newly incurred claims.

  - **Extended grace periods.** For plan years ending in 2020 and 2021, health and dependent care FSAs may extend grace periods up to 12 months after plan year-end. Any balance remaining at the end of the grace period after the plan year ending in 2021 is forfeited. However, if the grace period was extended to the full 12 months, the employer could offer another grace period for the first 2-1/2 months after the plan year ending in 2022 (e.g., through March 15, 2023, for a calendar plan year). During that 2-1/2 month period, the balance can be used for newly incurred claims. Alternatively, a *health FSA* may be amended to permit a carryover of up to $550 (annually indexed) into the 2023 plan year from the balance available at the end of the

2022 plan year — which may include amounts contributed in 2021 if the health FSA allowed the full 12-month grace period.

  - **Health FSA spend-downs.** Employees ending health FSA participation during 2020 or 2021 (whether because of termination of employment, a change in employment status or a new election) can "spend down" any balance for the remainder of that plan year (and any grace period), without electing COBRA continuation coverage for the health FSA. This means that the individual can continue to seek reimbursement for claims incurred after, for example, employment has terminated.

- **For 2022, restore income exclusion limits for employer-provided DCAPs in effect before ARPA.** For the 2021 calendar year only, ARPA increased the income exclusion for employer-provided DCAPs — such as employee pretax contributions to dependent care FSAs — from $5,000 to $10,500 (and from $2,500 to $5,250 for a spouse filing a separate return). Employers were permitted — but not required — to increase their 2021 dependent care FSA limits accordingly. Watch for congressional action that could make this income exclusion limit permanent. If that happens, decide whether to extend or adopt the increase for 2022 and beyond.

Determine whether to continue (or to adopt) the permanent enhancements to account-based plans permitted under the CARES Act and IRS guidance.

- **Maximum health FSA carryover amount.** IRS Notice 2020-33 permits — but does not require — a health FSA to increase the amount an employee can carry over into the next plan year to 20% of the current year's pretax contribution limit. Thus, the maximum carryover amount from a health FSA plan year starting in 2021 to the next plan year is $550 (20% of the 2021 contribution limit of $2,750).

- **HSA, HRA and health FSA reimbursement of costs for over-the-counter (OTC) drugs without a prescription, menstrual care products and COVID-19 PPE.** The CARES Act and IRS Announcement 2021-7 permit — but do not require — HRAs and health FSAs to reimburse costs for OTC drugs without a prescription, menstrual care products, and COVID-19 PPE, such as hand sanitizer, face masks and sanitizing wipes. This change applies retroactively to Jan. 1, 2020. HSAs may reimburse such expenses on a tax-free basis.

- **HSA-qualifying HDHPs may permit pre- or no-deductible coverage of COVID-19 testing and treatment.** IRS Notice 2020-15 permits HSA-qualifying HDHPs to cover COVID-19 testing and treatment before individuals have met the deductible, without jeopardizing their eligibility to make or receive HSA contributions. HDHPs must cover COVID-19 *testing* without cost sharing during the COVID-19 public health emergency (currently renewed through Oct. 17, 2021), but HDHP coverage for COVID-19 *treatment* free of cost sharing is optional.

Adopt Section 125 plan amendments for COVID-19 relief by the applicable deadline.

- Amend the Section 125 plan for any relief offered employees. Although Section 125 plan documents usually must be amended before a change takes effect, COVID-19 relief permits retroactive amendments within specific time frames. Different deadlines for noncalendar-year

plans are noted below, but work with counsel to confirm the deadlines for a particular noncalendar-year plan. The first plan amendments for account-based plans are due Dec. 31, 2021.

- **Plan amendments due Dec. 31, 2021:**
  - Amendment allowing employees to revoke an FSA election, make a new FSA election, or decrease or increase an existing FSA election without a change-in-status event during the plan year ending in 2020
  - Amendment allowing uncapped FSA carryovers from the plan year ending in 2020 into the plan year ending in 2021
  - Amendment extending the FSA grace period from 2-1/2 months to as many as 12 months after the plan year ending in 2020
  - Amendment increasing the health FSA carryover amount from the plan year ending in 2020 into the plan year ending in 2021 to $550 (indexed annually)
    - For subsequent plan years, the amendment deadline to increase the FSA carryover amount is the end of the plan year from which amounts may be carried over. Calendar-year plan sponsors increasing the health FSA carryover limit from 2021 into 2022 must amend their plans by Dec. 31, 2021. Noncalendar-year plans must do so by the last day of the plan year beginning in 2021.
  - Amendment increasing DCAP contributions, such as allowing higher pretax employee contributions to a dependent care FSA, up to $10,500 for 2021 (or $5,250 for a spouse filing a separate return)
    - For a noncalendar-year plan, the deadline is the last day of the plan year in which the amendment is effective. Since this ARPA change is for the 2021 *calendar year*, a noncalendar-year plan may require amendment by the last day of the plan year ending in 2021 *and* the last day of the plan year ending in 2022. Employers sponsoring noncalendar-year plans that took advantage of this provision should work with counsel to determine when plan amendments are due.
  - Amendment permitting health FSAs (HRAs may need a similar amendment) to reimburse participants' costs for OTC drugs without prescriptions, COVID-19 PPE and menstrual care products during the plan year ending in 2020
    - Part IV of IRS Notice 2021-15 appears to allow retroactive amendments for reimbursement of costs for menstrual care products and OTC drugs without a prescription, even if those amendments are made after Dec. 31, 2021. However, including these expenses with the Dec. 31, 2021, amendment for PPE would be a prudent approach.

- Amendment allowing an employee who terminates participation in a calendar-year health FSA during 2020 to incur claims through the end of the 2020 plan year
  - For noncalendar-year plans, the amendment deadline is the last day of the calendar year beginning after the plan year in which the amendment takes effect. A noncalendar-year plan using this relief might have two amendment deadlines. For example, if a plan with a plan year beginning June 1, 2019, allowed an employee terminating March 31, 2020, to incur claims through the plan year ending May 31, 2020, the amendment would be due Dec. 31, 2021. If that plan allowed an employee terminating Sept. 30, 2020, to incur claims through the plan year ending May 31, 2021, the amendment would be due Dec. 31, 2022.
- Amendment for a calendar-year plan that allowed reimbursements from the 2020 dependent care FSA balance for qualifying expenses related to children who turn age 13 in the 2020 or 2021 plan year
  - A noncalendar-year plan must determine its amendment deadline under Notice 2021-15.

- **Plan amendments due Dec. 31, 2022:**
  - Amendment allowing employees to revoke an FSA election, make a new FSA election, or decrease or increase an existing FSA election without a change-in-status event during the plan year ending in 2021
  - Amendment allowing uncapped FSA carryover amounts from the plan year ending in 2021 into the plan year ending in 2022
  - Amendment extending the FSA grace period from 2-1/2 months to as many as 12 months after the plan year ending in 2021
  - Amendment permitting health FSAs (HRAs may need a similar amendment) to reimburse participants' costs for COVID-19 PPE, if this change first took effect during 2021
  - Amendment for a calendar-year plan increasing the health FSA carryover amount to $550 (indexed annually) from the 2022 plan year into the 2023 plan year, if this change first takes effect for the 2022 plan year
    - For noncalendar-year plans beginning in 2022, the deadline is the last day of the 2022 plan year.

Revise HSA, HDHP and excepted-benefit HRA limits for 2022 amounts in Rev. Proc. 2021-25.

- **Annual HSA contribution limits.** The 2022 contribution limits will increase to $3,650 (self-only) and $7,300 (family) — up from $3,600 and $7,200 in 2021. The annual catch-up contribution for individuals ages 55 and older remains $1,000 (not indexed).

- **HDHP in-network out-of-pocket (OOP) limits.** The OOP limits will increase to $7,050 (self-only) and $14,100 (family) in 2021, up from $7,000 and $14,000 in 2021. HDHPs can set lower — but not higher — caps on in-network OOP expenses. The ACA's higher OOP limits ($8,700 for self and $17,400 for family coverage in 2022) for nongrandfathered group health plans apply only when an HDHP must embed an ACA individual in-network OOP limit into family HDHP coverage.

- **HDHP minimum annual deductible.** The minimum deductibles for 2022 will remain $1,400 (self-only) and $2,800 (family), unchanged from 2020 and 2021.

Excepted-benefit HRA annual maximum contribution. The 2022 maximum annual employer contribution to an excepted-benefit HRA will remain $1,800, unchanged from 2022 and 2021.

Identify pre- or no-deductible health benefits, programs or point solutions that could jeopardize an individual's eligibility to make or receive HSA contributions, and confirm strategy.

- Look broadly at telehealth services (unless COVID-19 temporary relief is extended into 2022), on-site medical clinics, wellness programs, expert medical-opinion services, executive supplemental health benefits, international and travel health plans, coupons for prescription drugs or manufacturer discounts, or specialized care or disease-management programs. Examples of such programs include diabetes control, genetic tests, sleep apnea treatment, maternity support, fertility and infertility services, and behavioral health support. Keep in mind that long-standing IRS guidance permits predeductible preventive care and health benefits that don't provide significant medical care, such as certain on-site clinics, disease-management programs, wellness plans or EAPs.

Consider whether pending IRS regulations on individual-coverage HRAs, DPCAs and account-based health plans will impact benefit strategy and compliance efforts.

- **Individual-coverage HRAs.** Final regulations issued in January 2021 detailed how individual-coverage HRAs interact with the ACA's ESR requirements and the nondiscrimination rules for self-funded group plans under Section 105(h) of the tax code. However, those rules were withdrawn due to a White House memo freezing certain Trump administration regulations. For now, employers may rely on the 2019 proposed regulations. Employers offering or considering individual-coverage HRAs should monitor whether the Biden administration issues new final rules about how an employer offering individual-coverage HRAs can avoid ESR assessments.

- **DPCAs**. A DPCA is a contract between an individual and one or more primary care physicians who agree to provide medical care for a fixed annual or periodic fee without billing a third party. Proposed IRS regulations would allow HRAs to reimburse all types of DPCA fees, but health FSA and HSA reimbursements are likely limited to DPCA charges for medical care (but not membership fees, which might be viewed as akin to insurance premiums). The latest semiannual regulatory agenda indicates IRS may finalize these rules this fall. Employers whose benefit strategy includes DPCAs should monitor whether IRS pursues a different course under the Biden administration. Finally, as long as a DPCA is considered a health plan or medical insurance, an individual covered by the DPCA cannot make or receive HSA contributions. (Note that pending legislation and

proposals would allow HSA-eligible individuals covered by DPCAs to make or receive HSA contributions.)

- **Possible guidance clarifying deductible medical expenses and tax dependents.** The latest semiannual regulatory agenda includes proposed IRS rules clarifying deductible medical and dental expenses under Section 213 and final rules on the definition of tax dependent under Section 152. Review these rules once issued for any impact on HRA, HSA or health FSA reimbursements.

Monitor legislative efforts to make permanent the increased DCAP income exclusion limits, expanded dependent care tax credit and first-dollar HSA-qualifying HDHP coverage of telehealth.

- **Expanded dependent care tax credit.** President Biden's proposed infrastructure legislation, the American Families Plan, calls on Congress to make permanent ARPA's one-year expansion of the dependent care tax credit. However, the plan does not call for extending ARPA's higher DCAP amounts. If such legislation were enacted, pretax contributions to dependent care FSAs could become less attractive to employees, particularly if ARPA's higher limits on dependent care FSA contributions — up to $10,500 — are allowed to expire after 2021.

- **First-dollar HDHP coverage of telehealth.** While the COVID-19 telehealth expansion for HDHPs is set to expire Dec. 31, 2021 (for calendar-year plans), proposed bipartisan legislation (S 1704) would make this relief permanent.

Related resources

8

State activity

Action

Track state legislation affecting health and leave benefits, including paid leave, reporting obligations, PBM restrictions and telehealth laws. Work with carriers and vendors to ensure compliance with any new coverage mandates, and evaluate any cost increases. Monitor ERISA preemption litigation that may impact state laws affecting employee benefit plans.

Specific steps

Work with vendors to strengthen compliance.

- Assess current PFML and sick leave benefits against any relevant state and local mandates, and revise plans as needed. Establish a process for complying with new and expanded paid leave mandates and programs. Work with payroll, insurance and other vendors to implement contribution collection, coordinate with existing employer-provided paid leave and design a private PFML plan (if permitted). Multijurisdictional employers should consider developing a long-term strategy for equalizing leave benefits across jurisdictions and administering increasingly complex programs.

- Verify that PBM contracts align with state PBM laws and regulations. Determine to what extent those state provisions affect self-insured ERISA plans in light of the Supreme Court's *Rutledge v. Pharmaceutical Care Management Association* decision (140 S. Ct. 812 (2020). That ruling held that ERISA does not preempt an Arkansas law regulating the cost paid by PBMs to pharmacies. Review the cost impact of PBM laws. Look for more state efforts to regulate PBMs as a result of *Rutledge*.

- Establish processes for complying with various state reporting obligations, including reporting obligations under Washington's new long-term care law (WA Rev. Code Ch. 50B.04, as amended by 2021 Ch. 113). Work with vendors to streamline where possible.

- As states seek to broaden access to telehealth, consider expanding telehealth benefits, especially for behavioral health. Use of telehealth for mental healthcare may increase as more states join the Psychology Interjurisdictional Compact (PSYPACT), an initiative that facilitates the cross-state practice of telepsychology and temporary in-person, face-to-face psychology.

Work with carriers to address state initiatives affecting insured plans.

- Ask about the premium cost impact of state insurance mandates, such as fertility benefits for same-sex couples, mental health parity changes, and other new or expanded health coverage mandates.

- Confirm the plan's state of issue (situs), and determine whether new insurance provisions apply in other states where employees work or reside.

Watch for court rulings that may impact ERISA preemption.

- Monitor the ERISA Industry Committee (ERIC)'s litigation concerning ERISA's preemption of a Seattle healthcare ordinance. The district court, upheld on appeal, found that ERISA does not preempt Seattle's mandate that hotel employers make certain healthcare expenditures, by either making a direct payment or providing group health plan coverage. ERIC has requested a rehearing. A win for Seattle could spur similar state and local mandates for employers, including those sponsoring self-funded plans.

Related resources

9

Preventive services

Action

Confirm nongrandfathered group health plans offer all ACA-required in-network preventive services without cost sharing. Modify 2022 benefits for the latest ACA guidance and any new or updated USPSTF, HRSA and ACIP recommendations, including coverage of "qualifying coronavirus preventive services." Note the CAA requirement that the USPSTF's pre-2009 recommendation to begin breast cancer screening, mammography and prevention at age 40 rather than 50 is in effect until Jan. 1, 2023.

Specific steps

Timely update a nongrandfathered group health plan's preventive services covered without cost sharing for the latest ACA guidance and any new or revised USPSTF, HRSA and ACIP recommendations.

- Coverage generally must conform for plan years that begin on or after the one-year anniversary of the date when a preventive care recommendation or guideline was issued or updated. However, plans must cover COVID-19 vaccines and other preventive items or services within 15 days after ACIP recommends them or USPSTF gives them an A or a B recommendation.

- A USPSTF recommendation or guideline is considered to be issued on the last day of the month in which USPSTF publishes or releases the recommendation. The issuance date of an ACIP recommendation or guideline is considered to occur when the CDC director adopts it. An HRSA recommendation or guideline is deemed to be issued once accepted by the HRSA administrator or, if applicable, adopted by the HHS secretary.

Monitor development of COVID-19 tests and vaccines.

- **COVID-19 tests and related services.** All group health plans, including grandfathered plans, must cover COVID-19 tests and related services without any cost sharing (including deductibles, copayments and coinsurance), prior authorization, or other medical-management requirements during the public health emergency. The public health emergency, currently set to expire on Oct. 17, is renewed in 90-day increments by the HHS secretary. HHS has indicated that the public health emergency will likely continue through all of 2021. Plans should consider covering COVID-19 tests free of cost sharing even after the public health emergency expires.

- **COVID-19 vaccines and administration costs.** Nongrandfathered group health plans must cover all COVID-19 vaccines and associated administration costs without any cost sharing (including

deductibles, copayments and coinsurance) within 15 business days (excluding weekends and holidays) after the USPSTF or ACIP recommendation takes effect. As of this article's publication date, the CDC has adopted ACIP recommendations for three COVID-19 vaccines: the Pfizer-BioNTech vaccine for persons ages 12 or older, along with the Moderna and Janssen (Johnson & Johnson) vaccines for persons ages 18 or older. Grandfathered group health plans should consider covering the vaccine free of cost sharing as well.

Add or update no-cost in-network coverage of preventive services with a USPSTF A or B recommendation issued in 2020 and effective Jan. 1, 2022, for calendar-year plans. For noncalendar-year plans, the effective date could be the plan year beginning in 2021 or 2022, depending on when the plan year starts relative to the date USPSTF issued the recommendation.

- **Hepatitis C virus (HCV) infection screening for adults ages 18–79.** Screen for HCV infection in adults ages 18–79. This recommendation incorporates new evidence and replaces one from 2013 by expanding the population who should be screened. USPSTF previously recommended screening of persons at high risk for infection and one-time screening of adults born between 1945 and 1965. (Issued March 2020)

- **Tobacco use prevention counseling for children and adolescents younger than ages 18.** Provide interventions, including education or brief counseling, to prevent initiation of tobacco use, including e-cigarettes, among school-age children and adolescents. This recommendation is consistent with one from 2013 but adds e-cigarettes as a tobacco product. The recommendation also has a new "I statement" finding insufficient evidence to assess the balance of benefits and harms from primary care interventions for the *cessation* of tobacco use among school-age children and adolescents. (Issued April 2020)

- **Unhealthy drug use screening for adults ages 18 or older.** Screen by asking questions about unhealthy drug use (without testing biological specimens) in adults ages 18 years or older. Screen only when able to offer or refer to services for accurate diagnosis, effective treatment and appropriate care. This recommendation is new and replaces one from 2008, which found insufficient evidence at that time to recommend screening for illicit drug use in adolescents and adults, including pregnant or postpartum persons. USPSTF continues to find insufficient evidence to assess the balance of benefits and harms of drug use screening for adolescents. (Issued June 2020)

- **Sexually transmitted infection (STI) prevention counseling for sexually active adolescents and higher-risk adults.** Provide behavioral counseling for all sexually active adolescents, as well as adults with increased risk for STIs. This updated recommendation is consistent with one from 2014 but recommends a broader range of effective counseling approaches, including ones involving less than 30 minutes of total contact time. USPSTF continues to find insufficient evidence on the benefits and harms of behavioral counseling to prevent STIs in nonsexually active adolescents and in adults not at increased risk for STIs. (Issued August 2020)

- **Healthy diet and physical activity counseling for adults ages 18 or older with cardiovascular disease (CVD) risk factors.** Offer or refer adults ages 18 or older with CVD risk factors to behavioral counseling interventions to promote a healthy diet and physical activity. Individuals with increased risk of CVD have one or more of the following: (i) hypertension or elevated blood pressure, (ii) dyslipidemia, or (iii) mixed or multiple risk factors, such as metabolic syndrome or an estimated 10-year CVD risk of ≥7.5%. This recommendation is consistent with one from 2014 but no longer covers adults with impaired glucose tolerance or type 2 diabetes mellitus. That population is included in a separate 2015 USPSTF recommendation. (Issued November 2020)

- **Hepatitis B virus (HBV) infection screening for at-risk adolescents and adults.** Screen for HBV infection in adolescents and adults at increased risk for infection. This recommendation is consistent with one from 2014 but backed by new evidence from trials and cohort studies. That evidence shows antiviral therapy reduces the risk of mortality and hepatocellular carcinoma and improves intermediate outcomes consistently associated with better health outcomes. (Issued December 2020)

Prepare to add or update no-cost in-network coverage of preventive services with a USPSTF A or B recommendation issued in 2021 and effective Jan. 1, 2023, for calendar-year plans. For noncalendar-year plans, the effective date could be the plan year beginning in 2022 or 2023, depending on when the plan year starts relative to the date USPSTF issued the recommendation.

- **Tobacco use cessation behavioral interventions for all adults and pharmacotherapy for all nonpregnant adults.** Ask all adults — including pregnant persons — about tobacco use, advise them to stop using tobacco and provide behavioral interventions. Also provide nonpregnant adults FDA-approved pharmacotherapy for tobacco use cessation. This recommendation is consistent with one from 2015 but incorporates new evidence on the harms of e-cigarettes (i.e., vaping) and a description of the 2019 e-cigarette or vaping associated lung injury (EVALI) outbreak in the US. USPSTF finds insufficient evidence on the benefits and harms of pharmacotherapy for pregnant persons and the use of e-cigarettes for tobacco cessation. USPSTF notes that clinicians should direct patients to other cessation interventions with proven effectiveness and established safety. (Issued January 2021)

- **Lung cancer screening for adults ages 50–80 with a 20 pack-year smoking history — defined as 20 years of smoking at least 20 cigarettes (one pack) per day — who currently smoke or have quit within the past 15 years.** Screen for lung cancer with low-dose computed tomography (LDCT) in adults ages 50–80 years with a 20 pack-year smoking history who currently smoke or have quit within the past 15 years. Discontinue screening once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. This recommendation replaces one from 2013 by lowering the age range to 50 (from 55) years and reducing the pack-year history to 20 (from 30). (Issued March 2021)

- **Hypertension screening for adults ages 18 or older.** Screen for hypertension in adults ages 18 or older with office blood pressure measurement (OBPM). USPSTF recommends obtaining blood

pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment. This recommendation reaffirms one from 2015 but advises the use of OBPM for initial screening, updates language to reflect current evidence, and clarifies implementation strategies. (Issued April 2021)

- **Colorectal cancer screening for adults ages 45–75.** Screen for colorectal cancer in all adults ages 45–75. This recommendation replaces one from 2016 by lowering the recommended age range to 45 (from 50). (Issued May 2021)

- **Healthy weight and weight gain behavioral counseling for pregnant adolescents and adults.** Offer effective behavioral counseling to promote healthy weight gain and prevent excessive gestational weight gain in pregnancy in all pregnant adolescents and adults. (Issued May 2021)

- **Any additional preventive services recommended during 2021.** If any additional preventive-service recommendations are issued in 2021 (after the date of this article), ensure noncalendar-year plans comply by the applicable 2022 or 2023 effective date and calendar-year plans comply by Jan. 1, 2023.

Ensure proper coverage of pre-exposure prophylaxis (PrEP) medication with effective antiretroviral therapy for persons at high risk of human immunodeficiency virus (HIV) infection.

- **Confirm coverage for PrEP without participant cost sharing includes baseline and monitoring services to ensure PrEP is administered safely and efficiently, as clarified by recent agency FAQs.** These services include HIV testing (prior to PrEP administration and every three months thereafter), hepatitis B and C testing, creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR), pregnancy testing, sexually transmitted infection (STI) screening and counseling and adherence counseling.

- **Verify the plan's reasonable medical management techniques do not restrict the frequency of benefits for PrEP services specified in the USPSTF recommendation, such as HIV and STI screening.** However, plans may use reasonable medical management techniques to steer individuals prescribed PrEP toward specific items and services, as long as the USPSTF recommendation does not specify the frequency, method, treatment or setting. For example, plans may cover a generic version of PrEP without cost sharing and impose cost sharing on an equivalent branded version, with certain exceptions for medical appropriateness.

Check ACIP's list of vaccines to determine if the plan must add new vaccines to cover free of cost sharing.

Maintain coverage of ACA-mandated women's contraceptives, unless the employer has religious or moral objections to contraceptives.

- Continue to cover all FDA-approved women's contraceptives without cost sharing, unless declining or revoking this coverage due to moral or religious objections.

- If asserting a religious or moral objection, decide whether to voluntarily adopt an accommodation — or revoke an existing accommodation — allowing participants to obtain women's contraceptive coverage, if available, directly from the insurer or the TPA.
  - Nongovernmental employers with sincerely held religious or moral objections to contraceptives may exclude ACA-mandated coverage of some or all FDA-approved women's contraceptives, under 2018 final regulations upheld by the Supreme Court (*Little Sisters of the Poor v. Pennsylvania*, 140 S. Ct. 2367 (2020)). However, ongoing litigation on this issue and the potential for the Biden administration to amend these rules leave uncertainty about the future of these exemptions.
  - The religious exemption is available to all types of nongovernmental employers, including nonprofit entities, privately held and publicly traded for-profit corporations, churches, and institutions of higher education that arrange student health insurance coverage.
  - The moral exemption is available to the same entities described above, with the exception of publicly traded corporations.

Monitor ongoing class action litigation seeking to invalidate *all* recommended ACA-mandated preventive services as unconstitutional and unenforceable, so group health plans would no longer have to cover those services without participant cost sharing. The outcome of this case and the resulting group health plan implications are uncertain.

Update official plan documents, SPDs, SBCs and other materials as needed.

Related resources

10

Other ongoing ACA concerns

Action

Review 2022 group health plan coverage and eligibility terms in light of ESR strategy, ESR and MEC reporting duties, and ACA benefit mandates. Determine whether changes made by the final grandfathered health plan rule published in December 2020 can help preserve grandfathered status (if applicable). Continue to calculate and pay the PCORI fee for self-funded health plans, and prepare for MLR rebates. Monitor ongoing litigation challenging various ACA provisions, including the obligation for nongrandfathered group health plans to cover preventive services without participant cost sharing.

Specific steps

Review planned 2022 benefits against ESR standards, including MEC for ACA full-time employees and the minimum value and affordability of health coverage.

- Evaluate required employee contributions for the lowest-cost, self-only option against the 2022 affordability percentage and the employer affordability safe harbors. For 2022, the ESR required contribution percentage will decrease to 9.61%, down from 9.83% in 2021.
  - **2022 calendar-year plans.** The maximum monthly 2022 employee contribution for the lowest-cost, self-only option for employers using the federal poverty level (FPL) affordability safe harbor will decrease to $103.15, from $104.53 in 2021.
    - This marks the first time that the FPL safe-harbor dollar amount has decreased for calendar-year plans. As a result, employers that use this safe harbor will need to reduce the employee contribution for the lowest-cost, self-only option for the 2022 plan year. The same is possible for noncalendar-year plans beginning in 2022, depending on the 2022 FPL amounts issued in late January 2022.
  - **Noncalendar-year plans beginning in 2022.** Once the 2022 FPL amounts are issued in early 2022, a noncalendar-year plan beginning in 2022 can calculate the maximum monthly employee contribution using the FPL affordability safe harbor by multiplying 9.61% by the 2022 FPL amount, and dividing the result by 12. (Note: Noncalendar-year plans beginning in 2021 continue to use $105.51 — calculated as (9.83% x $12,880 FPL for 2021) ÷ 12 — as the FPL safe harbor amount for months in 2022 until their new 2022 noncalendar-year plan starts.)

- Check for updated IRS Q&As (#55) giving the 2022 ESR assessment amounts. Mercer projects the 2022 ESR assessments will be:
  - $2,750 (up from $2,700 in 2021) per ACA full-time employee for employers that do not offer MEC to at least 95% of ACA full-time employees (and their dependents), and at least one of those employees receives federally subsidized coverage through a public exchange
  - $4,120 (up from $4,060 in 2021) per ACA full-time employee receiving federally subsidized coverage through a public exchange because the employee wasn't among the 95% of ACA full-time employees offered employer MEC or received an offer of employer MEC that was unaffordable or less than minimum value

Consider benefit-eligibility terms or health benefit alternatives for part-time or former employees who don't trigger ESR assessments when not offered MEC.

- Weigh how the need for employer coverage may change. Demand could increase due the pent-up need for healthcare postponed during the pandemic, the long-term health effects of COVID-19 or resurgence of the pandemic due to variants. Public exchange coverage may be more accessible due to ARPA's temporary increase in subsidies for 2021 and 2022, which the Biden administration is looking to make permanent.
- Consider offering a stand-alone telehealth program, an expanded EAP or an on-site clinic to employees ineligible for the traditional group health plan. Agency guidance temporarily permits an excepted-benefit EAP to cover COVID-19 diagnostic and testing services and allows certain stand-alone telehealth programs to avoid many ACA market reforms. Employer on-site medical clinics can offer expanded services and retain excepted-benefit status in all circumstances (i.e., excepted-benefit status for on-site clinics is not dependent on temporary COVID-19 guidance). (For more information, see COVID-19 issues for health plans.)

Ensure adequacy of ESR recordkeeping and reporting.

- IRS continues to issue ESR assessments. The agency first began notifying employers in late 2017 about their potential liability for the 2015 calendar year (when the ESR mandate took effect). IRS has actively collected assessments from applicable large employers every year since. In a December 2019 memorandum, the agency concluded that no statute of limitations applies to ESR assessments, suggesting assessment letters could come more than three years after the calendar year to which they apply.
- Check for reporting errors that can result in inaccurate ESR assessments. The Treasury Inspector General for Tax Administration (TIGTA) finds that employer reporting errors cause most adjustments to proposed ESR assessments. Some employers have made the same reporting error two years in a row. The most common mistake leading to a revised assessment involved reporting on Form 1094-C that the employer did not offer MEC to at least 95% of ACA full-time employees (and their dependents) when the employer actually did satisfy that threshold.

- Address any Forms 1094-C or 1095-C reporting deficiencies identified in an initial IRS assessment Letter 226-J, and correct prior-year reports as necessary. Confirm that recordkeeping suffices to respond to any future IRS assessment letters.

- Plan for 2021 reports due in 2022, and continue to collect information for 2022 reports due in 2023. Confirm the appropriate measurement method — lookback or monthly — is used to identify ACA full-time employees.

- If offering an individual-coverage HRA, plan to review the 2021 IRS Form 1095-C and instructions (when issued) for any changes to the line 14 codes designed to accommodate ESR and premium tax credit reporting.

Review plan design for compliance with ACA benefit mandates.

- Continue to comply with ACA benefit mandates, such as waiting-period restrictions, the ban on lifetime and annual dollar limits for EHBs, the required first-dollar coverage of specified preventive services, and the 2022 annual in-network out-of-pocket maximums (OOPMs) for EHBs (i.e., $8,700 for self-only and $17,400 for other than self-only coverage).

- Employers sponsoring grandfathered plans should review the final triagency rule, first applicable on June 15, 2021, that amends the requirements for preserving grandfathered status. The final rule provides an alternative inflation measure, based on the HHS annually published premium adjustment percentage, to determine the maximum increase in the fixed-dollar cost-sharing amounts that will not cause a plan to lose grandfathered status. According to regulators, this alternative measure of inflation better accounts for changes in health coverage costs over time, potentially allowing grandfathered plans to maintain that status longer. The final rule also allows HSA-qualifying HDHPs to make IRS-required increases to minimum annual deductibles, even if the added amount exceeds the maximum percentage increase permitted by the grandfathered health plan rule. To date, however, the annual cost-of-living adjustment to HDHP minimum annual deductibles has yet to exceed the maximum percentage increase that would cause loss of grandfathered status.

Confirm use of most recent SBC templates during open enrollment.

- Use the most recent models to prepare SBCs for open enrollment for the first plan year starting on or after Jan. 1, 2021. Updated materials include an SBC template, uniform glossary, sample completed SBC, instructions and guides for coverage example calculations — each in multiple languages. Changes to the coverage calculator may result in different values for coverage examples, even when the plan design has not changed. The 2021 models replace 2017 versions.

- Review updated instructional guides for specific instructions on how to account for HRAs, HSAs and other healthcare accounts, along with health plan features like wellness programs.

Review any proposed changes to selected state benchmark plans.

- If using a state benchmark plan to identify which covered benefits are — or are not — EHBs subject to in-network OOPMs and the ban on annual or lifetime dollar limits, review the selected benchmark for any changes applicable in 2022, and consider other states' updates (if any).

Continue to calculate and pay the PCORI fee for self-funded group health plans, including certain HRAs and retiree-only plans.

- The PCORI fee remains in place for plan years ending before Oct. 1, 2029 (i.e., through the 2028 calendar-year plan). The fee funds research on the clinical effectiveness of various medical treatments and care options. Carriers are responsible for paying the fee for insured plans.
  - The fee due July 31, 2022, for noncalendar-year or short calendar-year plans ending in 2021 before Oct. 1 is $2.66 (up from $2.54 for the prior year) multiplied by the average number of lives covered under the plan.
  - The adjusted applicable fee per covered life due July 31, 2022, for 2021 calendar-year plans and noncalendar-year plans ending in 2021 on or after Oct. 1 will likely be announced this fall.

If sponsoring a fully insured group health plan, prepare for continued MLR rebates. The ACA requires these rebates if an insurer fails to spend a minimum percentage of premiums on healthcare claims and quality improvements.

- Expect MLR rebates issued in 2021 in the small- and large-group market to be lower than the record high issued in 2020. Nonetheless, the Kaiser Family Foundation projects MLR rebates in 2021 will be the second largest since rebates were first issued in 2012.s
  - Although MLR rebates are based on a three-year average — e.g., 2018–2020 financial data for 2021 rebates — the large rebates expected reflect suppressed healthcare utilization during the pandemic. Hospitals and providers cancelled elective care and plan participants chose to forgo care in 2020. While insurer expenses increased for telehealth services and COVID-19 testing, vaccines, and treatments, these expenses did not offset the decreases in in-person care. Insurers that waived certain patient costs or provided premium holidays in 2020 may owe less in rebates.
- Review plan documents for language addressing the handling of rebates, and follow those provisions accordingly. If plan documents are silent, consider an amendment to address rebates, refunds, plan distributions and other details. When the plan document is silent, the employer must determine how much of the rebate is a plan asset that must be used to benefit participants.
  - Nonfederal government employers and church plans should consult HHS rules on the management of MLR rebates.
  - Once informed about a carrier's intent to issue a rebate, communicate with plan participants on how the rebate will be handled.

- Predicting the pandemic's continued effect on rebates payable in 2022 is difficult. On the one hand, the public health crisis forced the cancellation of elective procedures and caused many individuals to delay or forgo care. On the other hand, with the pandemic extending beyond one year, pent-up demand for care in 2021, costs associated with COVID-19 vaccines and long-term health effects of the virus could increase insurer costs.

Monitor ongoing litigation challenging certain ACA provisions and/or implementing regulations.

- In a 7–2 decision, the US Supreme Court rejected a constitutional challenge to the individual health coverage mandate in a case that could have invalidated the entire ACA (*California v. Texas*, No. 19- 840 (US June 17, 2021)). The decision maintained the status quo for employer group health plans. The ACA's mandated first-dollar coverage of specified preventive services, ban on lifetime and annual dollar limits for EHBs, prohibition of preexisting condition exclusions, limits on waiting periods, and caps on in-network OOP expenses continue unchanged. The ESR mandate also remains intact, along with the annual reporting obligations.

- Other legal challenges to specific ACA regulations continue, including litigation over the Section 1557 nondiscrimination rules (see Gender and family planning issues in benefits), moral and religious exemptions from the women's contraceptive coverage mandate, and mandated coverage of other preventive services. These matters will likely take years to resolve, but agencies could change some regulations before the court challenges are complete.

Related resources

Related resources

In this appendix, links to all Law & Policy resources on Mercer Link are accessible only to Mercer consultants. Clients and prospects may contact their consultants for copies or access 2019 and later GRISTs via the Law & Policy Group's webpage and library on www.mercer.com/our-thinking.html.

1. COVID-19 issues for health plans

Non-Mercer resources

- Notice 2021-46, Premium assistance for COBRA benefits, part 2 (IRS, July 26, 2021)
- State action related to COVID-19 coverage: Expanding access to affordable coverage options insurers (The Commonwealth Fund, last updated June 28, 2021)
- Announcement 2021-7, Amounts paid for certain personal protective equipment treated as medical expenses (IRS, March 26, 2021)
- ACA FAQs, part 44 (DOL, HHS and Treasury, Feb. 26, 2021)
- Disaster relief notice 2021-01 (DOL, Feb. 26, 2021)
- Notice 2021-15, Additional relief for coronavirus disease (COVID-19) under § 125 cafeteria plans (IRS, Feb. 18, 2021)
- Interim final rule, Additional policy and regulatory revisions in response to the COVID-19 public health emergency (Federal Register, Nov. 6, 2020)
- ACA FAQs, part 43 (DOL, HHS and Treasury, June 23, 2020)
- Notification of relief, Extension of certain time frames for employee benefit plans, participants and beneficiaries affected by the COVID-19 outbreak (Federal Register, May 4, 2020)
- Disaster relief notice 2020-01 (DOL, April 28, 2020)
- ACA FAQs, part 42 (DOL, HHS and Treasury, April 11, 2020)
- Pub. L. No. 116-136, the CARES Act (Congress, March 27, 2020)
- Pub. L. No. 116-127, the FFCRA (Congress, March 18, 2020)
- FAQs on EHB coverage and COVID-19 (CMS, March 12, 2020)

Mercer Law & Policy resources

- IRS Q&As explain ARPA's COBRA premium subsidy program (June 16, 2021)
- DOL releases model COBRA subsidy notice and forms (April 20, 2021)
- Tracking federal COVID-19 laws affecting employee benefits, jobs (March 30, 2021)
- COBRA subsidies in COVID-19 rescue plan require employer action (March 29, 2021)
- Agencies issue new FAQs on COVID-19 testing, vaccines (March 9, 2021)
- Deadline relief continues for health plans and participants (March 4, 2021)
- COVID-19 vaccine considerations for group health plans (Dec. 21, 2020)
- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)

Other Mercer resources

- Navigating coronavirus (regularly updated)
- IRS clarifies FSA relief in CAA, provides more flexibility for cafeteria plan elections (Feb. 25, 2021)
- Employers ask for changes as Congress mulls future of telehealth (March 11, 2021)
- COVID-19 relief for health plans: How long does it last? (Dec. 3, 2020)

2. Maintaining a safe, healthy workplace

Non-Mercer resources

- Coronavirus (COVID-19) website (CDC)
- COVID-19 workplace safety (OSHA)
- Coronavirus and COVID-19 website (EEOC)
- Essential protections during the COVID-19 pandemic (DOL Wage and Hour Division)
- Vaccine recommendations and guidelines (ACIP)
- Guidance on 'long COVID' as a disability under the ADA, Section 504 and Section 1557 (HHS and Justice Department, July 26, 2021)
- FAQs about FFCRA and CARES Act, Part 44 (DOL, HHS and Treasury, Feb. 26, 2021)

Mercer Law & Policy resources

- Roundup: COVID-19 resources for employers (regularly updated)
- States, cities tackle COVID-19 paid leave (regularly updated)
- Tracking federal COVID-19 laws affecting employee benefits, jobs (March 30, 2021)
- Agencies issue new FAQs on COVID-19 testing, vaccines (March 9, 2021)
- COVID-19 vaccine considerations for group health plans (Dec. 21, 2020)
- Employer health plans have to meet new COVID-19 coverage mandate (April 21, 2020)
- COVID-19 raises HIPAA privacy, security issues (April 6, 2020)

Other Mercer resources

- Navigating coronavirus (regularly updated)
- Return to the workplace with confidence (regularly updated)
- EEOC: Vaccine incentives are permitted (June 3, 2021)
- Mercer joins coalition backing COVID-19 vaccine efforts (Feb. 25, 2021)
- Should employers incentivize workers to get vaccinated? (Jan. 28, 2021)
- Employers can mandate the COVID-19 vaccine, but should they? (Dec. 10, 2020)
- Employer groups encourage federal funding, support for COVID-19 testing (July 23, 2020)
- Worksite employee COVID-19 testing covered by insurance? Not so fast! (July 16, 2020)
- Tough issue arising as workers return: At-risk employees and the ADA (July 16, 2020)
- Open enrollment communications: Reaching & engaging employees during COVID-19 (July 7, 2020)

3. Transparency for group health plans, insurers and hospitals

Non-Mercer resources

- FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation, Part 49 (DOL, HHS and Treasury, Aug. 20, 2021)

- Proposed rule, Medicare program: Hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs; price transparency of hospital standard charges; radiation oncology model; request for information on rural emergency hospitals (Federal Register, scheduled for publication on Aug. 4, 2021)
- Fact sheet, CY 2022 Medicare hospital outpatient prospective payment system and ambulatory surgical center payment system proposed rule (CMS-1753-P) (July 19, 2021)
- Press release, CMS proposes rule to increase price transparency, access to care, safety and health equity (July 19, 2021)
- Interim final rule, Requirements related to surprise billing; Part I (Federal Register, July 13, 2021)
- Executive Order 14036, Promoting competition in the American economy (White House, July 9, 2021)
- Request for information regarding reporting on pharmacy benefits and prescription drug costs (Federal Register, June 23, 2021)
- Pub. L. No. 116-260, the Consolidated Appropriations Act, 2021 (Congress, Dec. 27, 2020)
- Final transparency in coverage rules (Federal Register, Nov. 12, 2020)
- Presentation: Hospital price transparency rule (CMS, Dec. 3, 2019)
- Final transparency rule for hospitals (Federal Register, Nov. 27, 2019)

Mercer Law & Policy resources

- Mercer, ERIC comment on CAA prescription drug reporting rules (July 23, 2021)
- Healthcare cost transparency rules and MLR changes finalized (Dec. 2, 2020)
- Mercer comments on proposed transparency in coverage rules (Jan. 31, 2020)
- Executive order targets healthcare price and quality transparency, and HSA/FSA changes (July 10, 2019)

Other Mercer resources

- Regulators clarify implementation timeline of transparency provisions (Aug. 25, 2021)
- Mercer and ERIC comment letter on prescription drug reporting rules (July 23, 2021)
- Biden executive order targets drug costs, other healthcare issues (July 15, 2021)

- Surprise billing interim final rule released (July 8, 2021)
- Decision support tools and healthcare cost transparency (March 18, 2021)
- Healthcare transparency rules (March 4, 2021)
- Transparency rules: 5 considerations for employers (Nov. 12, 2020)
- New transparency rule requires plan sponsors to disclose costs up front (Oct. 29, 2020)
- Mercer comment letter on transparency in coverage regulations (Jan. 29, 2020)
- The new transparency regulations: Will consumers finally be able to shop for healthcare? (Nov. 12, 2019)

4. Surprise billing

Non-Mercer resources

- FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation, Part 49 (DOL, HHS and Treasury, Aug. 20, 2021)
- Interim final rule, Requirements related to surprise billing; Part I (Federal Register, July 13, 2021)
- Model notice of surprise billing protections for group health plans and health insurance issuers (DOL, July 1, 2021)
- Hybrid approach to resolving payment disputes breaks legislative stalemates over balance billing; how will the No Surprises Act affect these new state laws? (Center on Health Insurance Reforms, April 13, 2021)
- State balance-billing protections (The Commonwealth Fund, last updated Feb. 5, 2021)
- Pub. L. No. 116-260, the 2021 CAA (Congress, Dec. 27, 2020)

Mercer Law & Policy resources

- Tracking federal COVID-19 laws affecting employee benefits, jobs (March 30, 2021)

Other Mercer resources

- Groups urge surprise billing rules that control costs, protect patients (June 24, 2021)

5. Gender and family planning issues in benefits

Non-Mercer resources

- *Fain v. Crouch*, No. 3:20-0740 (S.D. W. Va. June 28, 2021)
- Notification of interpretation and enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972 (Federal Register, May 25, 2021)
- Private letter ruling 109450-20 (IRS, April 9, 2021)
- Executive Order 13988, Preventing and combating discrimination on the basis of gender identity or sexual orientation (Federal Register, Jan. 25, 2021)
- *Whitman-Walker Clinic v. HHS*, No. 20-1630 (D.D.C. Sept. 2, 2020)
- *Walker v. Azar*, No. 20-2834 (E.D.N.Y. Aug. 17, 2020)
- Sexual orientation and gender identity discrimination (EEOC)
- ACA Section 1557 (42 USC § 18116)
- Internal Revenue Code Section 137
- Publication 502, Medical and dental expenses (IRS, updated annually)
- FAQs about Affordable Care Act implementation (Part XXVI) (DOL, May 11, 2015)

Mercer Law & Policy resources

- ACA 1557 nondiscrimination rule revised, but what is effective now? (Nov. 5, 2020)
- Justices' Title VII ruling on LGBTQ bias has health benefit impacts (June 15, 2020)

Other Mercer resources

- Turning health risk into value: Are your health and well-being approaches inclusive? (June 9, 2021)
- New survey finds employers adding fertility benefits to promote DEI (May 6, 2021)
- On the DEI journey, health equity must be a goal (March 11, 2021)
- Supreme Court's LGBTQ decision spurs legislation, lawsuits (June 18, 2020)

- Historic ruling confirms LGBTQ+ work protections (June 15, 2020)
- Does your health plan meet the needs of transgender individuals? (March 29, 2019)
- Changes signal shift in diversity and inclusion benefits (Sept. 6, 2018)

6. Mental health parity

Non-Mercer resources

- FAQs about MH/SUD parity implementation and the CAA 2021, Part 45 (DOL, HHS and IRS, April 2, 2021)
- Fact sheet, FY 2020 MHPAEA enforcement (DOL, Jan. 15, 2021)
- Pub. L. No. 116-260, the 2021 CAA (Congress, Dec. 27, 2020)
- MHPAEA self-compliance tool (DOL, Oct. 23, 2020)
- Mental health parity and substance use disorder resources (DOL)

Mercer Law & Policy resources

- Mental health parity compliance gets a boost in 2021 spending act (April 13, 2021)
- Mental health parity FAQs address nonquantitative limits (Dec. 17, 2019)

Other Mercer resources

- New law aims to improve mental health parity compliance; DOL tool will help (Jan. 7, 2021)

7. HSA, HRA and FSA developments

Non-Mercer resources

- Publication 969, HSAs and other tax-favored health plans (IRS, annually updated)
- Renewal of determination that a public health emergency exists (HHS, July 19, 2021)
- S 1704, Telehealth Expansion Act of 2021 (Congress, May 19, 2021)
- Notice 2021-26, Taxation of dependent care benefits available pursuant to an extended claims period or carryover (IRS, May 10, 2021)
- Rev. Proc. 2021-25, 2022 inflation-adjusted HSA,HDHP and excepted-benefit HRA amounts (IRS, May 10, 2021)

- Fact sheet: The American Families Plan (White House, April 28, 2021)
- Agency rule list: Treasury Department (Office of Information and Regulatory Affairs, spring 2021)
- Announcement 2021-7, Amounts paid for certain personal protective equipment treated as medical expenses (IRS, March 26, 2021)
- Pub. L. No. 117-2, the American Rescue Plan Act of 2021 (Congress, March 11, 2021)
- EBSA Disaster Relief Notice 2021- 01 (DOL, Feb. 26, 2021)
- Continuation of the national emergency concerning the coronavirus disease 2019 (COVID–19) pandemic (Federal Register, Feb. 26, 2021)
- Notice 2021-15 (IRS, Feb. 18, 2021)
- Regulatory freeze pending review (White House, Jan. 20, 2021)
- Pub. L. No. 116-260, the 2021 CAA (Congress, Dec. 27, 2020)
- FAQS about FFCRA and CARES Act implementation, part 43 (DOL, June 23, 2020)
- Proposed rule, Certain medical care arrangements (Federal Register, June 10, 2020)
- Notice 2020-33, Modification of carryover rule for health FSAs and clarification of premium reimbursements by individual-coverage HRAs (IRS, May 12, 2020)
- Notice 2020-29, COVID-19 relief for cafeteria plans and HDHPs (IRS, May 12, 2020)
- Joint DOL and IRS notice, Extension of certain time frames for employee benefit plans, participants and beneficiaries affected by the COVID-19 outbreak (Federal Register, May 4, 2020)
- Pub. L. No. 116-136, the CARES Act (Congress, March 27, 2020)
- Notice 2020-15, HDHPs and expenses related to COVID-19 (IRS, March 11, 2020)
- Proposed rule, Application of the ESR provisions and certain nondiscrimination rules to HRAs and other account-based group health plans integrated with Individual health insurance coverage or Medicare (Federal Register, Sept. 30, 2019)
- Final rule, HRAs and other account-based group health plans (Federal Register, June 20, 2019)
- FAQs on individual coverage and excepted-benefit HRAs (DOL, June 13, 2019)

Mercer Law & Policy resources

- 2022 HSA, HDHP and excepted-benefit HRA figures set (May 11, 2021)

- Tracking federal COVID-19 laws affecting employee benefits, jobs (March 30, 2021)
- COBRA help, dependent care items in COVID-19 bill near enactment (March 10, 2021)
- Deadline relief continues for health plans and participants (March 4, 2021)
- 2021 quick benefit facts (Jan. 21, 2021)
- Summary of 2021 benefit-related cost-of-living adjustments (Jan. 21, 2021)
- IRS offers relief to cafeteria plans, HDHPs, individual-coverage HRAs (May 28, 2020)
- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)
- COVID-19 spurs IRS relief for HDHPs, state insurance guidance (March 18, 2020)
- IRS outlines how individual-coverage HRAs can meet ACA employer mandate (Oct. 29, 2019)
- Final rules ease restrictions on health reimbursement arrangements (June 14, 2019)

Other Mercer resources

- Biden seeks paid leave, dependent care help in sweeping family aid plan (April 29, 2021)
- Which is better — dependent care FSA or the tax credit? (April 8, 2021)
- Employers ask for changes as Congress mulls future of telehealth (March 11, 2021)
- New outbreak period guidance requires plan action (March 2, 2021)
- IRS clarifies FSA relief in CAA, provides more flexibility for cafeteria plan elections (Feb. 25, 2021)
- Big news for employers — long-sought answers on how to handle unused 2020 FSA balances and much more! (Dec. 23, 2020)
- COVID-19 relief for health plans: How long does it last? (Dec. 3, 2020)
- Direct primary care gains ground as employer strategy (July 9, 2020)
- Could free COVID-19 services sabotage your HSA? IRS just weighed In (March 12, 2020)

8. State activity

Non-Mercer resources

- PSYPACT

- ERIC urges 9th Circuit Court of Appeals to revisit Golden Gate case decision & protect ERISA from further overreach (ERIC, April 30, 2021)
- Petition for *en banc* rehearing of ERISA Industry Committee v. Seattle, No. 20-35472 (9th Cir., April 30, 2021)
- *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474 (2020)

Mercer Law & Policy resources

- New Mexico enacts paid sick leave law (May 19, 2021)
- Washington adds tight exemption timeline to long-term care law (May 3, 2021)
- Roundup of selected state health developments, first-quarter 2021 (April 26, 2021)
- Oregon's paid family and medical leave contributions begin in 2022 (March 11, 2021)
- California broadens its mental health parity law (March 11, 2021)
- Paid sick leave mandates continue to expand at state level (Feb. 8, 2021)
- Roundup of selected state health developments, fourth-quarter 2020 (Feb. 3, 2021)
- 2021 state paid family and medical leave contributions and benefits (Jan. 20, 2021)
- Supreme Court upholds Arkansas law regulating PBMs (Dec. 10, 2020)
- States increase group health plan reporting obligations (Nov. 20, 2020)
- Seattle healthcare expenditure for hotels survives ERISA challenge (Aug. 4, 2020)

9. Preventive services

COVID-19 testing and vaccine mandate

Non-Mercer resources

- Renewal of determination that a public health emergency exists (HHS, July 19, 2021)
- How CDC is making COVID-19 vaccine recommendations (CDC, May 14, 2021)
- COVID-19 vaccine toolkit for health and drug plans (CMS, May 14, 2021)
- FAQs about Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief and Economic Security (CARES) Act, Part 44 (DOL, HHS and Treasury, Feb. 26, 2021)

- Interim final rule, Additional policy and regulatory revisions in response to the COVID-19 public health emergency (Federal Register, Nov. 6, 2020)
- FFCRA and CARES Act FAQs, Part 43 (DOL, HHS and Treasury, June 23, 2020)
- FFCRA and CARES Act FAQs, Part 42 (DO, HHS and Treasury, April 11, 2020)
- Pub. L. No. 116-136, the CARES Act (Congress, March 27, 2020)
- Pub. L. No. 116-127, the FFCRA (Congress, March 18, 2020)
- ACIP vaccine recommendations and guidelines (ACIP)

Mercer Law & Policy resources

- Agencies issue new FAQs on COVID-19 testing, vaccines (March 9, 2021)
- COVID-19 vaccine considerations for group health plans (Dec. 21, 2020)
- Plan coverage of COVID-19 testing: Issues remain after June guidance (Sept. 15, 2020)
- Employer health plans have to meet new COVID-19 coverage mandate (April 21, 2020)
- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)

Other Mercer resources

- Mercer Link's coronavirus community (internal only)
- Navigating coronavirus (regularly updated)
- EEOC: Vaccine incentives are permitted (June 3, 2021)
- Mercer joins coalition backing COVID-19 vaccine efforts (Feb. 25, 2021)
- Should employers incentivize workers to get vaccinated? (Jan. 28, 2021)
- Employers can mandate the COVID-19 vaccine, but should they? (Dec. 10, 2020)
- Worksite employee COVID-19 testing covered by insurance? — Not so fast! (July 16, 2020)

ACA preventive services mandate

Non-Mercer resources

- Preventive health services (Healthcare.gov)

- USPSTF A and B recommendations (USPSTF)
- ACIP vaccine recommendations and guidelines (ACIP)
- Women's preventive services guidelines (HRSA)
- *Kelley v. Becerra*, No. 4:20-cv-00283-O (N.D. Tex. July 20, 2020); motion to dismiss decided (Feb. 25, 2021)
- Final rule, Coverage of certain preventive services under the ACA (Federal Register, July 14, 2015)

Mercer Law & Policy resources

- IRS expands predeductible preventive care for HSA-qualifying health plans (July 23, 2019)

Other Mercer resources

- Should employers cover colon cancer screenings at age 45? (June 24, 2021)
- Why do I keep getting billed for preventive health services? (Oct. 25, 2018)

ACA women's contraceptive-coverage mandate

Non-Mercer resources

- *Kelley v. Becerra*, No. 4:20-cv-00283-O (N.D. Tex. July 20, 2020)); motion to dismiss decided (Feb. 25, 2021)
- *Little Sisters of the Poor v. Pennsylvania*, 140 S. Ct. 2367 (2020)
- Final rule, Moral exemptions and accommodations for coverage of certain preventive services under the ACA (Federal Register, Nov. 15, 2018)
- Final rule, Religious exemptions and accommodations for coverage of certain preventive services under the ACA (Federal Register, Nov. 15, 2018)
- Final rule, Coverage of certain preventive services under the ACA (Federal Register, July 14, 2015)

Other Mercer resources

- Contraceptive coverage: Good for women, good for business (July 12, 2018)

10. Other ongoing ACA concerns

Non-Mercer resources

- Rev. Proc. 2021-36 (IRS, Aug. 30, 2021)
- Information on EHB benchmark plans (CMS)
- Medical loss ratio (CMS)
- Information reporting by providers of minimum essential coverage (IRS, June 26, 2021)
- PCORI fee (IRS, June 25, 2021)
- *California v. Texas*, No. 19-840 (US June 17, 2021)
- Data note: 2021 medical loss ratio rebates (Kaiser Family Foundation, April 12, 2021)
- *Kelley v. Becerra*, No. 4:20-cv-00283-O (N.D. Tex. July 20, 2020)); motion to dismiss decided (Feb. 25, 2021)
- Information reporting by applicable large employers (IRS, Jan. 22, 2021)
- Employer shared-responsibility provisions (IRS, Dec. 29, 2020)
- Final rule, Grandfathered group health plans and grandfathered group health insurance coverage (Federal Register, Dec. 15, 2020)
- ACA roundup: Record-high medical loss ratio rebates, pass-through funding, preventive services (Health Affairs blog, Nov. 17, 2020)
- Improvements are needed to ensure employer shared-responsibility payments are properly assessed (TIGTA, June 10, 2020)
- Memorandum 20200801F, Statute of limitations for IRC § 4980H (IRS, Dec. 26, 2019)

Mercer Law & Policy resources

- Affordable percentage will shrink for employer health coverage in 2022 (Sept. 2, 2021)
- Supreme Court rejects ACA challenge (June 17, 2021)
- 2022 ACA cost-sharing caps and other changes set; ESR penalties projected (May 18, 2021)

- 2021 federal poverty levels can impact ESR affordability (Jan. 27, 2021)
- 2021 quick benefit facts (Jan. 21, 2021)
- Summary of 2021 benefit-related cost-of-living adjustments (Jan. 21, 2021)
- Healthcare cost transparency rules and MLR changes finalized (Dec. 2, 2020)
- ACA individual statement due date, good-faith relief extended for 2021 (Oct. 13, 2020)
- Employers face ongoing liability for ACA play-or-pay assessments (March 2, 2020)

Other Mercer resources

- Permanent ACA reporting relief sought by employers (Feb. 4, 2021)
- Biden seeks COBRA subsidies, ACA enhancements, expanded paid leave (Jan. 21, 2021)

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