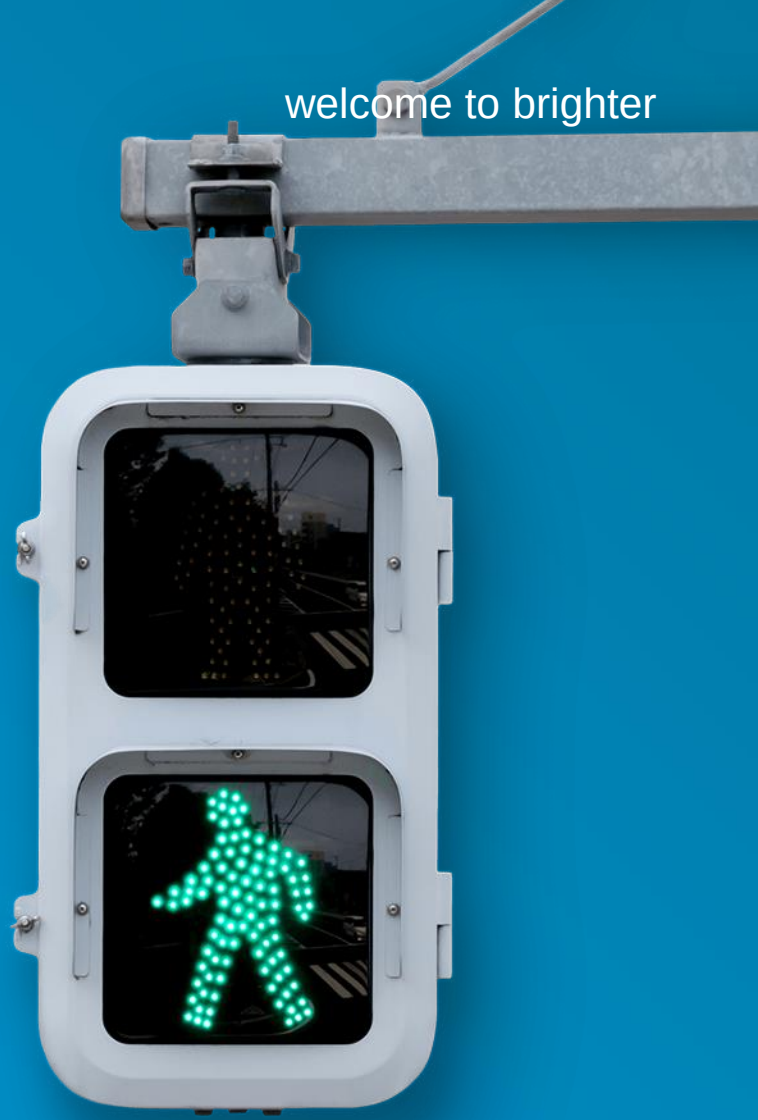
Mercer

welcome to brighter



Carolinas Chapter of ISCEBS

# Employer health benefits compliance update

February 24, 2022

A business of Marsh McLennan

# Speakers

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Principal

Katharine is a principal in Mercer's Law & Policy Group, a team of lawyers, actuaries, technical and government relations experts focusing on legislative, regulatory and judicial issues affecting employee benefits. Katharine works from her home in Chapel Hill, NC.

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Principal

Lindsey is a principal in Mercer's Regulatory Resource Group, a team of lawyers and regulatory specialists focused exclusively on group health plan and fringe benefit compliance issues. Lindsey works from her home in Durham, NC.

1. Legislative outlook
2. COVID-19
3. Transparency
4. Surprise billing
5. Mental health parity
6. Paid leave
7. Resources
8. Appendix

# Agenda

# Legislative outlook

# Democrats assess future of the Build Back Better Act

## Key senator's opposition brings focus on shorter priority list

**Outlook is murky for a compromise bill, but common ground could include:**

### Health

- Extend the temporary (2021-2022) expansion/increase of ACA marketplace subsidies through 2025
- Lower affordability threshold for ACA employer mandate from 9.5% (currently indexed at 9.61% for 2022) to 8.5% for 2022 through 2025; thresholds not indexed until 2027
- Permit individuals with household incomes at or below 138% of the federal poverty level to receive an exchange subsidy even if they have been offered affordable, minimum-value employer-sponsored coverage from 2022 through 2025; employer penalty would not apply
- Allow monetary penalties against employers and insurers for mental health parity violations

### Drug pricing reforms

- Medicare price negotiation for certain drugs; does not extend to commercial market
- Mandatory rebate by drugmakers for certain Medicare drugs with prices increasing faster than inflation; commercial market included in calculation of rebate

**Paid leave proposal is likely dead, but interest in issue will continue.**

# 2022 Agenda

## Telehealth, more COVID aid, healthcare costs

| | |
|---|---|
| **Telehealth** | Bipartisan legislation to revive expired CARES Act provision that allowed HSA qualifying HDHPs to cover telehealth and other remote care services on a predeductible basis without jeopardizing an individual's HSA eligibility. Lawmakers, employers, trade organizations are urging regulators to adopt nonenforcement policy in the meantime. |
| **COVID aid** | Democrat measure will need bipartisan support; may include telehealth extension, aid for small businesses |
| **Healthcare cost controls** | Ongoing interest in barring anti-competitive contracting terms between providers and health plans, increasing transparency of PBMs |
| **Mental health** | Bipartisan Senate interest in addressing mental health. Finance committee, other lawmakers are developing legislation to expand access to mental health services. |
| **Cures Act 2.0** | Bipartisan House bill aims to accelerate innovative therapies and drugs, and remove barriers to telehealth services |

# COVID-19

2

# Required coverage of OTC COVID-19 tests

**Pres. Biden Dec. 2, 2021, COVID action plan: Expand access and affordability of at-home COVID-19 tests**

FAQ Part 51 and Part 52: Group health plans must cover OTC COVID tests purchased on or after January 15, 2022, free of cost-sharing, prior authorization or medical management.

## Requirements

- OTC FDA-authorized tests must be covered when purchased for diagnostic purposes until the Public Health Emergency expires
  - No prescription or clinical assessment is required
  - Generally not required to cover tests for public surveillance or employment purposes
    - Note: Applicable state insurance law mandates, state OSHA requirements and/or state wage and hour laws may differ
- Minimum coverage: 8 tests per rolling 30-day period or calendar month
  - Enrolled family of 4 could obtain 32 tests in each 30-day period
  - OTC tests ordered by healthcare provider do not count towards this limit

**100% coverage is still required for testing with provider order or clinical assessment!**

- No participant cost-sharing (e.g., deductibles, co-payments)
  - Cannot limit coverage to tests obtained from preferred suppliers
  - Cannot create significant barriers to obtaining tests (e.g., no pre-authorization or other medical management techniques)
  - Can cap reimbursement at the lesser of cost or $12 per test from non-preferred supplier if and only if Direct Coverage Safe Harbor standards are satisfied (next slide)
- Avoiding fraud and abuse
  - Can take reasonable steps to ensure OTC purchased for personal use by enrollee (e.g., attestation that test is for personal use, will not be reimbursed by another source, and is not for resale)
  - Can require reasonable documentation (e.g., UPC code, receipt)
  - Can disallow private in-person or online person-to-person sales, online auction or resale marketplace with notice
  - Requiring multiple documents and/or multiple steps that unduly delay access to or reimbursement of test is not reasonable

# Direct coverage safe harbor

**Purpose: Facilitate access and provide for seamless experience in obtaining free OTC COVID-19 tests**

1

## Adequate access

Participants must have adequate access to in-person preferred pharmacy, retailer or distribution site and at least one direct-to-consumer shipping program

2

## No out-of-pocket costs

Participants must be able to obtain tests from preferred suppliers without any payment, including reasonable shipping costs from direct-to-consumer suppliers

3

## Delivery

Must not be delayed significantly longer than any other item in the direct-to-consumer shipping program; enforcement relief for supply shortages

4

## Information

Participants should receive information about the Direct Coverage program, including when it will be available, participating retailers, and the types of resellers not eligible for coverage or reimbursement

If the safe harbor criteria are met, plan can limit reimbursement for OTC tests purchased from non-preferred providers:

- Participant pays out-of-pocket and submits claim for reimbursement
- Reimbursement including sales tax and shipping costs limited to $12 per test (or actual cost, if less)

# Next steps

- **PBM/TPA/insurer coverage confirmation**
  - Are OTC tests covered by the medical or the pharmacy benefit, or both?
  - Is there a Direct Coverage option?
  - Is the Direct Coverage option be operational? (If not already, when?)
  - Do participants have to complete an attestation at point of sale or when submitting a claim for reimbursement?
  - Are participants required to submit documentation for reimbursement?
  - Confirm deductible and other cost-sharing is not applied to OTC tests
  - Insured plans: Review state law for OTC test coverage requirements for employment screening, return to work, travel, or school screening.
- **Develop participant communications**
  - Benefit booklet/SPD/website/other?
  - Provided by employer or plan?
- **Review implications for plan costs**

# Other COVID-19 testing and vaccine coverage requirements

## Testing (other than OTC)

Group health plans (including grandfathered plans) **must cover COVID-19 testing and related services without cost-sharing** to plan participants during the public health emergency.

- Includes the **test** and other **items and services** provided during the visit that result in an order for the test, as long as they relate to the **administration** of the test or the **evaluation** to determine the need for the test
  - Applies to both in- and out-of-network tests and related services
  - Prior authorization and medical management prohibited
  - Cannot impose medical screening criteria to deny coverage or impose cost sharing for asymptomatic individuals
- Does not include coverage of **tests for public health surveillance, employment** (e.g., return to workplace) or other purposes (e.g., back-to-school, travel)
- Plans *should* protect participants from inappropriate cost-sharing

## Vaccine

Nongrandfathered plans **must cover without cost sharing all COVID-19 vaccines** after adoption by the Centers for Disease Control (CDC).

- No cost in-network coverage of **vaccine and administration** required (including multiple-dose vaccines, additional dose for certain individuals, booster shots, and expansion to younger populations)
- Same coverage required for out-of-network providers during the public health emergency
  - Reasonable reimbursement required
- Cannot deny coverage based on individual not being in current category recommended for early vaccination

## Employers can:

- Offer testing and vaccines through excepted benefit EAP
- Offer testing and vaccines through on-site clinic
- Cover vaccines, testing, treatment, and related items in a HDHP, pre-deductible

# COVID-19 testing payment disputes

## Payers and providers have begun legal actions around payments for COVID-19 testing

- FFCRA requires group health plans to cover the cost of diagnostic testing and related services
- CARES Act requires plans reimburse out-of-network providers the publicly listed cash price or negotiate a lesser payment
- Payer groups continue to lobby Congress to protect against COVID-19 overcharges
- Providers allege wrongful denial of claims (see e.g., *Diagnostic Affiliates of Northeast Houston v. United Healthcare Services*, No. 21-cv-0131 (N.D. Tex. Jan. 18, 2022))
- Providers defending claims of price gouging (see e.g., *Premera Blue Cross v. GS Labs*, No. 2:21-cv-01399 (W.D. Wash. Oct. 14, 2021))

Note: Consider reviewing TPA processes and payments for out-of-network COVID-19 testing claims and watch for developments in these cases.

# Federally imposed COVID vaccine employer mandates

## Status update

### Private employers

- Supreme Court stayed OSHA's enforcement of the emergency temporary standard (ETS) that would have required employees of large employers to be vaccinated or tested while legal challenges continue (*Nat'l Fed'n of Indep. Bus. v. OSHA*, No. 21A244)
- Biden administration withdrew rule on Jan. 26, 2022
- **BUT** continued OSHA enforcement via *general duty clause*
- States and localities may have workplace safety requirements (e.g., Cal-OSHA and NYC)
- Employers can *voluntarily* require workers to vaccinate and/or test/mask, subject to state law

### Federal contractors

Vaccination requirement (no testing alternative) for federal contractors currently on hold nationwide as lawsuits challenging the mandate continue in multiple courts

### Healthcare workers

Supreme Court allowed CMS to enforce interim final rule (IFR) requiring healthcare workers in settings that receive Medicare or Medicaid funding to be vaccinated (no testing alternative) while legal challenges continue (*Biden v. Missouri*, No. 21A240)

# Vaccines in the workplace

## Vaccine requirements

- **Equal Employment Opportunity Commission** (EEOC) guidance permits employers to require workers entering the workplace be vaccinated against COVID-19 as long as they do not violate the **Americans with Disabilities Act** (ADA) and the **Civil Rights Act**.
  - ADA requires employers to reasonably accommodate employees who do not vaccinate because of a disability, unless it would pose an undue hardship to the business.
  - Title VII of the Civil Rights Act requires employers to reasonably accommodate employees who do not vaccinate because of sincerely held religious beliefs, unless it would pose an undue hardship to the business.
  - Title VII (as amended by the Pregnancy Discrimination Act) requires employers to make modifications or exceptions for employees not vaccinated due to pregnancy, if the employer does so for other employees. The modifications can be the same as accommodations made for an employee not vaccinated due to a disability or religious belief.
  - Information about vaccination status is considered confidential medical information under the ADA.
- **Most court rulings** have upheld employer vaccine mandates.
- Some **state laws** may limit an employer's ability to require vaccination as a condition of employment. See the National Academy for State Health Policy interactive map.

## Vaccine incentives

- Incentives for employees to provide documentation or other confirmation of vaccination are generally permissible under the ADA, the Genetic Information Nondiscrimination Act (GINA), and Title VII, according to EEOC guidance.
  - If the vaccine is administered by the employer or its agent, the incentive cannot be so substantial as to be coercive, and is not allowed for employees' family members.
  - But consider state law restrictions related to vaccine status
- Incentives in the form of cash, cash-equivalents (e.g., gift cards), and items and benefits that are more than de minimis, should be taxed as income.
- Incentives related to the group health plan trigger HIPAA wellness program rules.
  - Premium surcharges could affect ACA employer mandate affordability calculations, as the non-wellness rate must be used for wellness program incentives other than tobacco cessation.

# Group health plan COVID-19 vaccine incentives

## HIPAA rules

Group health plan **incentive/surcharge for COVID-19 status** must comply with HIPAA rules for health-contingent, activity-only wellness programs:

1. Provide annual opportunity to qualify for the full incentive
2. Ensure program is reasonably designed to promote health or prevent disease, and isn't overly burdensome
3. Confirm total incentives for all health-contingent wellness program elements doesn't exceed 30% of total cost of coverage (50% for tobacco use prevention)
4. Provide reasonable alternative standard (RAS) to participants for whom it is medically inadvisable or unreasonably difficult due to a medical condition to get the vaccine
5. Disclose availability of RAS in all materials describing wellness program

# Group health plan COVID-19 vaccine premium differential

**Employer considerations**

## Consider program design

Many variables impact employer compliance obligations. Consider scope of program, amount of incentive, availability of other wellness incentives, method of incentive delivery, and others.

## Account for affordability

For applicable large employers subject to the ACA's employer shared responsibility provisions, vaccine incentives tied to group health plan premiums will impact affordability. Use the rate for unvaccinated employees when performing the affordability analysis.

## Evaluate workforce impact

Consider employee demographics and impact a vaccine program will have on workplace safety, recruitment, and retention.

## Consult with counsel

Consider extent of, and tolerance for, legal risk related to a vaccine program. Work with counsel prior to implementation.

# COVID-19 group health plan relief

## Timeframes

**Public Health Emergency (PHE)** extended in 3-month increments (now through April 15, 2022)

- Group health plans *must* provide *no-cost* COVID-19 diagnostic *testing and related services*
- Employer *may* offer stand-alone telehealth to non-eligible employees and avoid ERISA and ACA compliance obligations
- 60-day advance notice requirement *waived* for certain changes to SBCs
- EAP *may* remain an excepted benefit even if coverage for COVID-19 diagnostic testing is added
- Some HIPAA privacy rules relaxed

**National Emergency (NE)** applies to **outbreak period extensions** for:

- Certain ERISA-required notices and disclosures
- HIPAA special enrollment periods
- COBRA elections and payments
- Claim filing deadlines

**EXPIRED telehealth flexibility for HSA-compatible HDHPs**

The CARES Act permitted HDHP plan years beginning on or before Dec. 31, 2021 to cover telehealth before deductible without affecting HSA eligibility

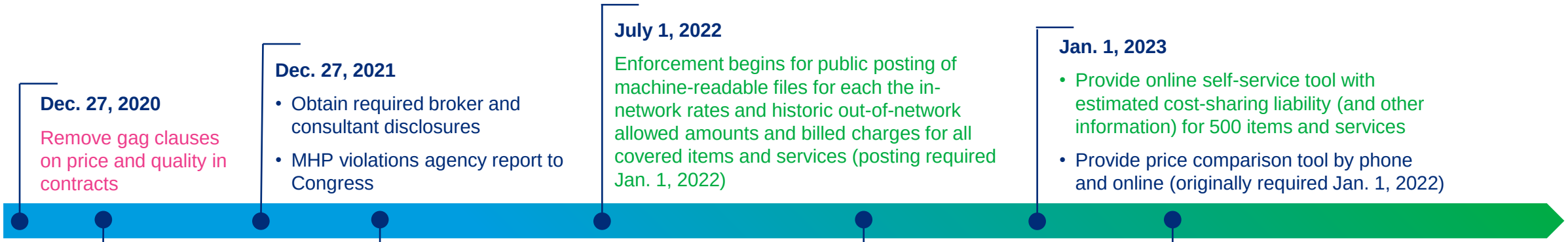
**Permanent Changes**

- Group health plans must cover COVID-19 vaccines and other preventive items and services without cost-sharing
- HSA-qualifying HDHPs can cover COVID-19 screening, testing, and treatment before the individual has reached the minimum HDHP deductible, beginning in 2020 and continuing until further guidance is issued

# Transparency

# Timeline of select employer benefit provisions

## Transparency and surprise billing



**Dec. 27, 2020**

Remove gag clauses on price and quality in contracts

**Feb. 10, 2021**

Disclose MHP NQTL comparative analysis upon request

**Dec. 27, 2021**

- Obtain required broker and consultant disclosures
- MHP violations agency report to Congress

**Jan. 1, 2022**

- Include deductibles, out-of-pocket maximums, customer assistance telephone number and web address on health plan ID cards
- Continuity of care patient protections
- Provider directories must be accurate and up to date
- Surprise billing ban on emergency services, air ambulances, and certain nonemergency services
  - Expanded coverage of emergency services
  - Balance billing protection disclosure on public website and each applicable EOB
  - Independent dispute resolution process
  - Expanded external review requirements

**July 1, 2022**

Enforcement begins for public posting of machine-readable files for each the in-network rates and historic out-of-network allowed amounts and billed charges for all covered items and services (posting required Jan. 1, 2022)

**Dec. 27, 2022**

Prescription drug benefits and costs reporting required (2020 and 2021 data)

**Jan. 1, 2023**

- Provide online self-service tool with estimated cost-sharing liability (and other information) for 500 items and services
- Provide price comparison tool by phone and online (originally required Jan. 1, 2022)

**Jan. 1, 2024**

Provide online self-service tool with estimated cost-sharing (and other information) for all covered times and services, including prescription drugs

Items in pink are subject to a **good faith compliance** requirement until guidance is issued.

Items in green are required under the **transparency-in-coverage rules** for group health plans.

**Note:** The Consolidated Appropriations Act, 2021 (CAA) requirement to provide advanced explanation of benefits (EOBs) with good faith estimates and the transparency-in-coverage rule requirement to publicly post a machine-readable file of prescription drug negotiated rates and historic net prices are both delayed pending guidance.

# Different approaches to transparency compliance

Due to complexity, short timeframe, and resource constraints, employers are taking one of three paths to comply with the public posting of the machine-readable files requirement:

**Minimum** level of effort to comply, leaning heavily on carriers to support good faith effort

**Strict compliance** utilizing expert support (e.g., legal, consulting), updating contractual language, documenting performance expectations and guarantees, and planning for period review and audit

**Strict compliance plus focus on user experience** with consolidated consumer too, plans to include quality data with the ultimate goal of helping plan members navigate to high value care

# Employer action items

**Fully insured group health plans**

- Obtain a written agreement from insurer
- With agreement in place, the plan will not be liable for the insurer's failure to comply

**Self-funded group health plans**

- Contract with TPA to provide the required disclosure
- Monitor TPA to ensure required disclosures are made
- Plan liable for any violations

# Pharmacy benefit reporting

All data, other than demographics, must be submitted on aggregate basis by the plan/insurer or vendor (TPA/PBM) reporting on their behalf. Check that service agreements address liability for and accuracy of data reported and opportunity for plan to review and confirm.

## Demographics

- Plan year beginning and end dates
- States in which plan is offered
- Number of participants/beneficiaries

## Cost

- Total healthcare spend by type
  - Medical
  - Hospital
  - Provider (primary and specialty)
  - Rx (hospital/medical and pharmacy)
  - Other (wellness)
- Average monthly premium paid by employer and employee

## Top 50 Rx

- Brand drugs most frequently dispensed (and number of claims paid for each)
- Most costly drugs (and amount spent for each)
- With greatest increase in expenditures from previous year (and amount spent)

## Rebates

- Rebates by therapeutic class
- Rebates paid for each of the 25 drugs with the highest amount of rebates
- Impact on premium or cost-sharing

## Due date

Dec. 27, 2022 (2020 and 2021 calendar-year data)

Subsequent reports due annually by June 1

## Data collection

By CMS Health Insurance Oversight System (HIOS)

Website with technical details, including file layout

Mercer response to RFI encourages cooperation requirements for PBMs, TPAs and insurers; exemptions for expat plans, stand-alone telehealth plans, and point-solutions with limited Rx drug benefit (excepted benefits already exempt); and good faith compliance relief for plans relying upon vendors for data reporting.

# Broker disclosure requirements

- **Compliance requires a good faith reasonable interpretation**: Covered service providers and plan fiduciaries expected to implement using a good faith reasonable interpretation of the ERISA disclosure requirement
  - Comprehensive implementing regulations are not expected
  - Refer to guidance for pension plan disclosure requirements (25 CFR § 2550.408b-2(c))
- Applicable to insured and self-insured **ERISA group health plan (including grandfathered plans) services providers**
  - **No exception for excepted benefits** including limited scope dental and vision plans, EAPs providing medical care, FSAs, wellness programs providing medical care, or HRAs
- **Variable compensation disclosures**
  - Disclose compensation in *reasonable ranges*
  - Fiduciary entitled to evaluate reasonableness of the compensation
- **Plan fiduciary action items**
  - Identify all consultants and brokers for any group health plan
  - Demand disclosure of any service provider that has not provided adequate disclosure
  - Analyze service providers' direct and indirect compensation
  - Document demand, receipt, and review of disclosures and determination that compensation is reasonable in light of services being provided

## Requirement

Brokers and consultants must disclose at the time of contracting a description of the services to be performed and **any direct or indirect compensation** that they reasonably expect to receive for the **brokerage or consulting services.**

**Effective for contracts signed (or renewed) on or after Dec. 27, 2021** where the broker or consultant reasonably expects $1,000 or more in *direct and indirect* compensation.

# Surprise billing

4

# Surprise billing ban

**Applies to group health plans including grandfathered plans.**

**Does not apply to retiree-only plans, health reimbursement arrangements, or excepted benefits.**

## Protecting patients from surprise medical bills from:

- Non-network emergency service providers and facilities
- Non-network nonemergency service providers at in-network facilities
- Non-network air ambulances providers

## Expansive surprise billing rules require:

- Covering **out-of-network (OON) emergency services** without prior authorization at in-network cost sharing
- **No balance-billing** from certain OON **ancillary service providers** at an in-network facility and air ambulances
- **No balance-billing** from other OON service providers without **prior notice and consent** (subject to certain exceptions)
- **Audits** and **prompt payment**
- **Binding arbitration** of certain OON claims
- **External review** to determine whether surprise billing rules apply
- **Continuity of care** provisions
- **Independent dispute resolution** process for certain charges that exceed estimates for uninsured
- **Provider non-discrimination rules**
- **Enforcement over noncompliant providers**
- **Air ambulance cost reporting**

# *Emergency services* expanded

*The ACA has imposed certain standards on nongrandfathered plans that cover hospital-based emergency services since 2010. The No Surprises Act expands on these coverage standards and applies them to both grandfathered and nongrandfathered plans. Emergency services must be covered without prior authorization, regardless of whether a provider or facility is in-network, and the cost sharing counts toward in-network deductibles and out-of-pocket maximums.*

**Emergency services include:**

- Services provided **in hospital emergency departments**, including routine **ancillary services** needed for evaluation
- Services provided in **independent free-standing emergency departments**
- Certain **post-stabilization services**, including outpatient observation or inpatient or outpatient stay, even outside of the emergency department*

* An exception applies if the individual can travel using nonmedical transport to an available in-network provider located within a reasonable distance and the provider/facility satisfies the notice and consent procedures.

**Plans cannot:**

- Limit coverage based on plan terms or conditions (other than an exclusion of emergency services or coordination of benefits, waiting periods or cost sharing)
- Deny coverage based on diagnostic codes (the prudent layperson standard applies)
- Impose limits on OON providers that are more restrictive than those for in-network emergency providers
- Deny coverage based on general plan exclusions (e.g. emergency services provided to pregnant dependent where the plan excludes dependent maternity care)
- Deny coverage because some time has passed between when symptoms began and when care was sought, or because symptoms didn’t come on suddenly

# *Non-emergency services* protected

*Cost sharing for OON nonemergency services provided without written consent at an in-network (participating) facility is limited to in-network amounts and accumulates toward in-network deductibles and out-of-pocket maximums.*

**In-network or participating healthcare facility** has a direct or indirect contractual relationship with the plan or issuer and includes:

- Hospital
- Hospital outpatient center
- Critical access hospital
- Ambulatory surgical center

**Note:** Urgent care centers and retail clinics are not considered healthcare facilities subject to the rule, but that could change with future rulemaking.

**Cost-sharing limitations** apply to items and services provided during a visit (even if the provider furnishing the service is not at the facility), including:

- Equipment and devices
- Telemedicine
- Imaging and laboratory services
- Pre- and post-operative services

**For example:** A lab sample collected at an in-network facility sent off site to an OON lab for analysis is subject to the cost-sharing limitation.

The same cost-sharing limitations apply **to air ambulance services** if the plan covers those benefits, even if it has no in-network providers.

# Notice requirements for plans and issuers

- Notice must be posted on **public website**, and on **each explanation of benefits** that contains an item or service covered by the No Surprises Act.
- Notice must be written in plain language and include:
  - Balance-billing restrictions
  - Applicable state law protections (can use state model language, if available)
  - Federal protections
  - Contact information for both state and federal agencies to report provider or facility noncompliance
- Plans and issuers can develop a notice, or use the model notice
  - Use of the model is sufficient for good faith compliance

# Cost sharing and provider payment rules

*In-network cost sharing applies to all protected emergency and non-emergency services and must count towards in-network deductible and out-of-pocket maximum.*

## Provider payments

- Plan must adjudicate a “clean claim” within 30 days.
  - Must send **initial payment amount** (or claim denial) **directly to the nonparticipating provider with required disclosures.**
  - Initial payment amount is determined by the APMA, state law, or agreement between the plan or issuer and provider or facility.
  - If determined by plan or issuer, must reasonably determine payment in full amount, based on relevant facts and circumstances and as required under the terms of the plan or coverage.

If the nonparticipating provider doesn’t think the initial payment is enough →

Provider can initiate negotiations within 30 days of the notice of denial or initial payment. →

Negotiation period is limited to 30 days.

If no agreement is reached, either party has 4 days to initiate the independent dispute resolution (IDR) process.

Binding arbitration.

### What is the Qualifying Payment Amount?

The QPA is the plan’s or issuer’s median contracted rate as of Jan. 1, 2019, for similar services in the geographic area, indexed.

**The QPA is key to determining how much a plan can charge a participant for services protected from surprise billing and the amount that must count toward any in-network deductible or out-of-pocket maximum** (unless the provider bills less than the QPA, a state law determines the allowed cost sharing, or an all-payer model agreement covers the item or service at issue).

- Self-insured plans can use all of the employer’s self-insured group health plans or all self-insured plans administered by the TPA.
- Issuers use all plans offered in that market (i.e., large group or small group).

# IDR process and costs

**IDR process between out-of-network (OON) providers and group health plans to determine the OON rate**

- Either party may initiate IDR
- Disputed claims may be batched and considered jointly as part of one payment determination if they are for same provider/facility/group of providers, for the same or similar services provided within the prescribed time period (generally, within 30 business days), paid by the same plan or issuer
- Standardized forms are available

IDR entity makes a binding determination, choosing one of the parties' offer ("baseball-style" arbitration)

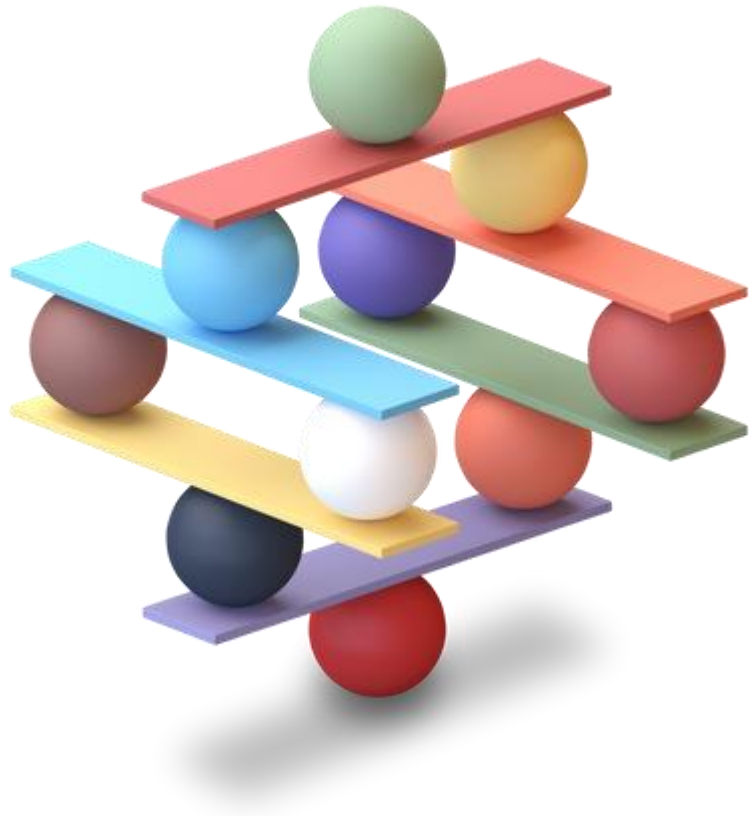
Rules contain certification process for IDR entities

**Costs**

- Each party pays an administrative fee ($50 for 2022)
- Nonprevailing party pays IDR entity's fee ($200 to $500 for single determinations, $268 to $670 for batched determinations)
- Participant cost-sharing does not change even if resulting OON rate is different than qualifying payment amount (QPA)

# Implications for shared savings fees

- **Current practice.** Many carriers take a fee on shared savings related to negotiation of OON claims. This fee may be as much as 25% - 30% of the negotiated savings. The rationale is that the TPA has saved the plan through its additional efforts, skills and resources.
- **Current landscape.** Mercer estimates about 5% of all claims are OON, and about 1% of all claims would be subject to the NSA. However, these claims tend to be high-cost claims (e.g., air ambulance).
- **Claims subject to the No Surprises Act (NSA).** TPAs may extend shared savings fees to NSA claims. However, any claim savings will largely be due to the NSA mandate in a regulated, uniform process, and no longer a value-add provided by the TPA.
- **Bundling.** NSA claims may routinely be batched such that a % fee or per claim fee is not appropriate.
- **Fully insured plans.** Carriers often use third parties that may have variable shared savings fees built into their processes.
- **Self-funded plans.** Evaluate administrative service agreements to reduce or eliminates shared savings fees for claims subject to the surprise billing protections.



# Plan member communications checklist for new transparency and surprise billing requirements

- ❑ **Surprise billing language**
  - Including new terminology and definitions (e.g., expanded definition of emergency services, post-stabilization services, non-emergency services protected from surprise bills, air ambulance services, emergency medical condition, emergency care, ancillary services, network facility, recognized amount, qualifying payment amount)
  - Cost-sharing applicable to claims subject to surprise billing protections and ban on balance bills
  - Waiver of surprise billing protections in certain circumstances
  - Surprise billing notice
- ❑ **External review for denied claims**
  - Including application to claims determined not to be protected by the surprise billing rules
- ❑ **Independent dispute resolution language**
  - Including new terminology and definitions (e.g., qualifying payment amount)
- ❑ **Transparency-in-Coverage (TiC) rules** (machine-readable files and future pricing tool)
  - Where to find and how to access information
- ❑ **ID card disclosures**
  - Deductibles, out-of-pocket maximums, customer assistance telephone number, web address
- ❑ **Continuity of care (transitional care)**
  - Requirement to continue covering services at in-network rates for beneficiaries with certain conditions when the provider or facility (or plan) terminates
- ❑ **Provider directories**
  - What to do if participant relies on an inaccurate directory
  - Requirement to provide written response following telephone inquiries

# Mental health parity

# Why employers need to pay attention to mental health parity rules

## Current Events

- COVID-19
- Opioid crisis
- Increased focus on autism and gender dysphoria

## Legislation and Regulatory Activity

- Continued legislative and regulatory focus on enhancing and enforcing existing MHPAEA rules
- 2021 Consolidated Appropriations Act (CAA) requires written NQTL comparative analysis
- Recent tri-agency report to Congress
- Increased agency outreach

## Litigation on the Rise

- Private litigations relating to claim denials for ABA therapy, gender dysphoria treatment, residential treatment centers for substance use disorders, etc., continue
- Class action lawsuits challenging plan coverage terms seeking the reprocessing of thousands of claims

## Ensuring access to MH/SUD care

- Adults exhibiting symptoms of anxiety or depression increased from 36.4% to 41.4% from Aug. 2020 to Feb. 2021
- An estimated 40.3 million people aged 12 or older battled a substance use disorder in 2020
- Over 100,000 Americans died of overdose during the 12 month period ending in April 2021 – a 30% year over year increase

# What is required?

## What is parity?

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires that any Mental Health and Substance Use Disorder (MH/SUD) benefits provided by a group health plan have parity with the plan's medical/surgical benefits in terms of:

| Financial requirements | Treatment Limitations | |
|---|---|---|
| *E.g. cost-sharing provisions* | Non-Quantitative *(e.g. preauthorization requirements)* | Quantitative *(e.g. caps on office visits)* |

## What does it apply to?

- Group health plans sponsored by private sector and governmental employers
- Grandfathered and non-grandfathered plans
- Insured and self-insured plans
- Self-funded non-federal governmental plans can opt-out of MHPAEA standards

## What is the risk for non-compliance?

- *From the IRS:* Excise tax of $100 per day for every covered individual to whom a failure relates, for every day that benefits are not provided
- *From employees:* Potential litigation

# Non-quantitative treatment limits

## An NQTL is a non-numerical limitation on the scope or duration of benefits for treatment

**Examples of NQTLs include, but are not limited to:**

- Exclusions of specific treatments for certain conditions
- Medical management standards limiting or excluding benefits based on medical necessity or based on whether the treatment is experimental/investigational
- Prior authorization or ongoing authorization requirements
- Formulary design for prescription drugs
- Provider admission standards and provider reimbursement rates
- Plan methods for determining usual, customary and reasonable charges
- Refusal to pay for higher cost therapies until it can be shown that lower cost therapy is not effective (i.e., fail first policies or step therapy programs)
- Exclusions based on failure to complete a course of treatment
- Restrictions based on geographic location, facility type, provider specialty and other criteria that limit the scope or duration for services provided under a plan

**An NQTL that is applied to MH/SUD coverage must be comparable to, and applied no more stringently than, the NQTLs that apply to medical/surgical coverage in the classification.**

# 2022 MHPAEA report to congress

| Fast Facts: None of the comparative analyses reviewed were sufficient | EBSA | CMS |
|---|---|---|
| Letters requesting NQTL analysis | 156* | 15 |
| Insufficiency letters issued requesting additional information | 80 | 19 |
| Initial determination of noncompliance letters issued | 30 | 15 |
| Corrective action plans received | 19 | 6 |

*Majority of DOL requests for NQTL comparative analyses derived from existing investigations. Letters sent to self-funded plans (134), fully insured plans (7), and insurers (15). Many still in process.

**“Common themes” in deficiencies**

- Failure to document comparative analysis before designing and applying NQTL
- Conclusory assertions lacking specific supporting evidence or detailed explanation
- Lack of meaningful comparison or meaningful analysis
- Non-responsive comparative analysis
- Documents provided without adequate explanation
- Failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classification(s) affected by an NQTL
- Limiting scope of analysis to only a portion of the NQTL at issue
- Failure to identify all factors
- Lack of sufficient detail about identified factors
- Failure to demonstrate the application of identified factors in the design of an NQTL
- Failure to demonstrate compliance of an NQTL as applied

# 2022 MHPAEA report to congress

## Continued

| Initial determination letters of noncompliance involved the following NQTLs: | N of D* | Initial determination letters of noncompliance involved the following NQTLs: | N of D* |
|---|---|---|---|
| Limitation or exclusion of applied behavior analysis therapy or other services to treat autism spectrum disorder | 9 | Employee assistance program referral requirement | 1 |
| Billing requirements – licensed MH/SUD providers can bill the plan only through specific types of other providers | 7 | Exclusion of care for chronic MH/SUD conditions | 1 |
| Limitation or exclusion of medication-assisted treatment for opioid use disorder | 4 | Exclusion of speech therapy to treat MH/SUD conditions | 1 |
| Preauthorization or precertification | 4 | Concurrent care and discharge planning requirements | 1 |
| Limitation or exclusion of nutritional counseling for MH/SUD conditions | 4 | Retrospective review | 1 |
| Provider experience requirement beyond licensure | 3 | Maximum allowable charge and reference-based pricing | 1 |
| Care manager or specific supervision requirement for MH/SUD | 2 | Other exclusion specifically targeting MH/SUD benefits | 1 |
| Exclusion or limitation on residential care or partial hospitalization to treat MH/SUD conditions | 2 | Age, scope, or durational limits | 1 |
| “Effective treatment” requirement applicable only to SUD benefits | 1 | Formulary design | 1 |
| Treatment plan requirement | 1 | Limit on telehealth for MH/SUD | 1 |
| | | Restriction on lab testing for MH/SUD | 1 |

*Number of determinations of noncompliance for that NQTL

# 2022 MHPAEA report to congress

## Continued

### Corrective action plans include:

- **Complete removal** of a specific NQTL limiting MH/SUD benefits, including changes to plan document language and changes to claims processing procedures
- **Addition of coverage** for MH/SUD benefits previously excluded
- **Reduction of scope** of an NQTL imposed on MH/SUD benefits
- **Notice** to participants and beneficiaries of a change in plan terms

### Legislative changes requested of Congress

- Give DOL authority to assess **civil monetary penalties** for parity violations
- Amend ERISA to give DOL authority to audit and **regulate TPAs** for parity compliance
- Amend ERISA to **require plans to repay losses** to beneficiaries whose claims were improperly denied under MHPAEA
- Expand access to **telehealth** (broadband access, interstate licensure)
- Amend MHPAEA to **define MH/SUD benefits** with reference to nationally recognized standards (such as DSM or ICD codes)

**Proposed amendments to MHPAEA's implementing regulations expected in July to clarify plans' and issuers' obligations, promote compliance, and update requirements.**

# NQTL comparative analysis: plan sponsor's role

## Self-funded group health plans

- Plan sponsor is responsible for compliance
- Determine level of support TPA can provide
- Additional complexity arises with nonstandard NQTLs, prescription drug carve-outs, and behavioral health carve outs
- Prepare a plan to respond to requests for the comparative analysis
- Require TPA assistance with compliance in future vendor contracts and RFPs

## Fully insured group health plans

Carrier is also subject to MHPAEA. Plan sponsors should confirm that they may rely on the carrier for compliance.

**Working towards compliance:**

- **Determine if TPA can provide the analysis for its fully insured plans, and determine to what extent it can be leveraged.**
- **If Rx is carved-out, determine if PBM can provide comparative analysis for its standard formulary and determine to what extent it can be leveraged.**
- **Determine if the plan has any NQTLs that are not in the TPA's fully insured plans or the PBM's standard formulary (non-standard NQTL).**
- **Evaluate how to conduct comparative analysis for non-standard NQTLs or consider removing them.**
- **Work with legal counsel to review analysis prepared by TPA/PBM to determine sufficiency.**
- **Work with legal counsel to address shortcomings and take corrective action.**
- **Review DOL MHPAEA self-compliance tool**

# Paid leave

# States, cities tackle COVID-19 paid leaves

## Law & Policy GRIST

### Latest update

**Feb. 10:** California passed a new COVID-19 supplemental paid sick leave requirement for employers with 25 or more employees. The requirement is retroactive to Jan. 1, 2022, and runs through Sept. 30, 2022.

### Spotlight: California supplemental paid sick leave (SPSL) reboot

- SB 114 signed into law Feb. 9, 2022
- Applies to employers with 26 or more employees
- California workers entitled to up to 80 hours of COVID-19 SPSL through Sept. 30, 2022
  - 40 hours for COVID-19-related reasons, including vaccinations/boosters and recovery from side effects for worker or family member
    - Can limit SPSL for each shot to 24 hours (or 3 days), unless otherwise indicated by healthcare provider
  - Additional 40 hours if worker or family member tests positive for COVID-19
- Must report SPSL taken on wage statement
- Model notice to be provided by Labor Commission must be posted (electronic distribution permissible)
- Retroactive to Jan. 1, 2022 (previous SPSL requirement expired Sept. 30, 2022)
  - Retroactive SPSL payments required upon request

# Paid family and medical leave

## National landscape

**Ten states**, along with **Washington, DC**, and **Puerto Rico**, have enacted laws requiring paid leave for an employee's own serious health condition or disability and — with the exception of Hawaii and Puerto Rico — for qualifying family or caregiving reasons

- California
- Colorado (contributions in 2023; benefits in 2024)
- Connecticut
- Hawaii (STD only)
- Massachusetts
- New Jersey
- New York
- Oregon (contributions in 2023; benefits in Sept. 2023)
- Puerto Rico (STD only)
- Rhode Island
- Washington
- Washington, DC

# Paid family and medical leave measures to watch

**States considering new PFML law**

- **Illinois** (HB 5029) – FML insurance program funded solely by employer contributions
- **Maine** (HB 1162) – PFML program funded 50/50 by employer and employees, not to exceed 0.7% of wages
- **Maryland** (HB 8/SB 275) – PFML program funded 50/50 by employer and employees, not to exceed 0.75% of wages
- **Minnesota** – No bills pending currently
- **New Mexico** (SM 1) – Law enacted in Feb. 2022, creating cross-functional team to recommend PFML program by Oct. 1, 2022
- **Vermont** (SB 65/HB 134) – Would amend unpaid PFML law to create insurance program; bills vary in funding
- **Virginia** (SB 15) – Creates voluntary class of PFML insurance; passed Senate on Feb. 10, 2022

**States considering expansion of current PFML law**

- **California** (AB 1949) – PFML would include up to 5 days for bereavement within 3 months of date of death of family member
- **New Hampshire** (HB 1582) – Would repeal current voluntary insurance program
- **Washington** (SB 5649) – addition of bereavement leave and post-natal care; passed Senate on Feb. 12, 2022

# Paid sick and safe leave

## National landscape

Currently, **16 states and Washington, DC** have enacted laws requiring employers to provide employees paid sick leave

* Maine and Nevada do not limit the permitted use of accrued paid leave time

| State | Effective date |
|---|---|
| Arizona | July 2017 |
| California | July 2015 |
| Colorado | Jan. 2021 |
| Connecticut | Jan. 2012 |
| Maine* | Jan. 2021 |
| Maryland | Feb. 2018 |
| Massachusetts | July 2015 |
| Michigan | March 2019 |

| State | Effective date |
|---|---|
| Nevada* | Jan. 2020 |
| New Jersey | Oct. 2018 |
| New Mexico | July 2022 |
| New York | Sept. 2020 |
| Oregon | Jan. 2016 |
| Rhode Island | July 2018 |
| Vermont | Jan. 2017 |
| Washington | Jan. 2018 |
| Washington, DC | May 2008 |

# Resources

7

# Law & Policy resources

- Regulators' first report on mental health parity analysis finds issues (Feb. 3, 2022)
- States, cities, tackle COVID-19 paid leave (Feb. 10, 2022)
- Mercer, ERIC provide more input on CAA prescription drug reporting (Jan. 28, 2022)
- Covering at-home COVID-19 tests: Your top questions answered (Jan. 20, 2022)
- 2022 state paid family and medical leave contributions and benefits (Jan. 19, 2022)
- Build Back Better Act's healthcare and paid leave reforms face uncertain future (Jan. 13, 2022)
- Employer vaccine-or-test rule on hold, healthcare worker mandate expands (Jan. 13, 2022)
- Plans must cover at-home OTC COVID-19 tests for free (Jan. 12, 2022)
- Health plans face new liabilities for inaccurate provider directories (Jan. 4, 2022)
- Prepare to comply with No Surprises Act notice requirements (Dec. 16, 2021)
- Mercer, stakeholder groups urge Congress to extend predeductible telehealth coverage (Dec. 9, 2021)
- Time to check your MAT coverage as overdose deaths reach new high (Dec. 2, 2021)
- Deadline relief continues for health plans and participants (Nov. 12, 2021)
- Top 10 compliance issues for health, fringe and leave benefits in 2022 (Sept. 7, 2021)
- Regulators clarify implementation timeline of transparency provisions (Aug. 25, 2021)
- Surprise billing interim final rule released (July 8, 2021)
- Healthcare cost transparency rules and MLR changes finalized (Dec. 2, 2020)

# Appendix

# Workplace nondiscrimination guidance for COVID-19

## EEOC guidance (last updated Dec. 14, 2021)

### Retaliation / interference related to equal employment opportunity (EEO) rights in connection with COVID-19 prohibited (section M)

- Examples of protected activity
  - Filing a complaint alleging unlawful disclosure of confidential medical information (e.g., COVID-19 diagnosis)
  - Reporting alleged EEO violation to supervisor or answering questions during investigation (e.g., comments accusing certain groups of people spreading COVID)
  - Resisting harassment, intervening to protect coworkers, or refusing to follow discriminatory orders (e.g., instructions not to hire based on sex-based presumption of childcare responsibilities)
  - Requesting accommodation (e.g., requesting continued telework as disability accommodation)
- Retaliation includes any employer action in response to EEO activity that could deter engagement in protected EEO activity
- Interference includes coercion, intimidation, threats, etc.

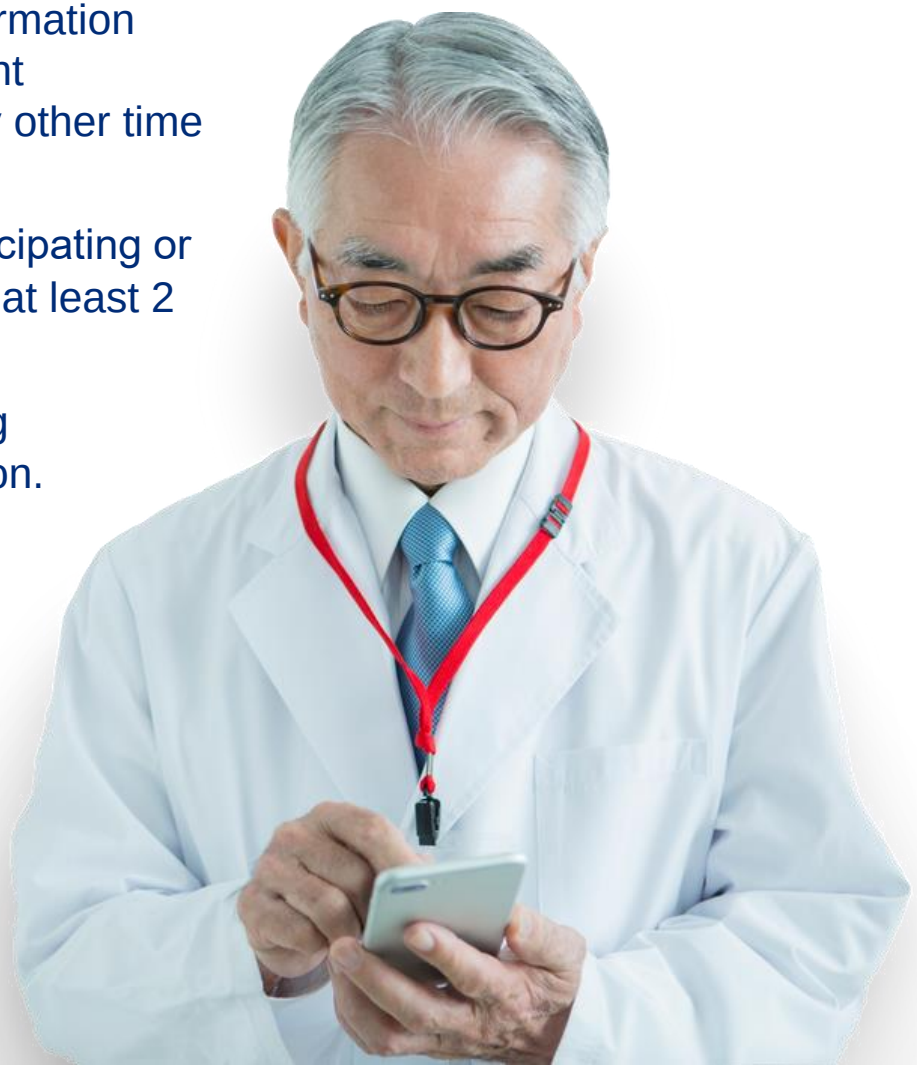
### COVID-19 can be an ADA Title I disability under each of the 3 definitions (section N)

- Actual disability: physical or mental impairment that substantially limits a major life activity such as walking, talking, seeing, hearing, or learning, or operation of a major bodily function (can be episodic)
  - Requires individualized assessment
- Record of disability: a history or “record of” an actual disability
- Regarded as an individual with a disability: subject to an adverse action because of an impairment or an impairment the employer believes the individual has
- Also – a condition caused or worsened by COVID-19 can be a disability

# Group health plan provider directories

- **Verify and update** at least once every 90 days provider directory on a public website.
  - Update database within 2 business days of receiving directory information from a provider when first joining network, when network agreement terminates, when there are material changes to the content, or any other time the plan receives info from the provider following a request.
- **Respond** to participant inquiries regarding provider's status as participating or non-participating within 1 business day and retain communication for at least 2 years.
- **Disclose** on public website and each EOB applicable surprise billing protections and state or federal contact information to report a violation.

**If directory (or inquiry response) incorrectly identifies provider/facility as participating, plan must apply cost sharing as if provider/facility were participating and count the cost sharing towards deductible and out-of-pocket maximum.**



# Healthcare price transparency

## Regulatory overview

**New transparency requirements aim to address wide price variations, reduce healthcare waste, and help individuals make informed choices**

Effective January 1, 2021

**Hospital** requirements to make standard charges public

- Comprehensive machine-readable file
- Display of shoppable services

Effective 2022-2024

**Group health plan/insurer** requirements to disclose out-of-pocket costs, negotiated rates

- Post publicly machine readable files
- Provide “self-service” tool

# Healthcare price transparency

## Regulatory overview

### Machine-readable files

**Plan years beginning 2022**

Post publicly 2 machine readable files[1]:

- Negotiated in-network provider rates *(7/1/22 enforcement delay)*
- Historic out-of-network allowed amount and billed amount *(7/1/22 enforcement delay)*

**Group health plans must disclose extensive price and cost-sharing information beginning in 2022**

### Price Comparison/Self-service Tool

**Plan years beginning 2023**

Provide online self-service tool with estimated cost-sharing liability (and other information) for 500 items and services. CAA requirements are likely to be incorporated.

**Plan years beginning 2024**

Provide online self-service tool with estimated cost-sharing liability (and other information) for all covered items and services, including Rx drugs.

[1] Third MRF, negotiated rates and historic net prices for drugs, delayed pending further guidance.

# Surprise billing

## Qualifying payment amount (QPA) presumed appropriate OON rate

IDR entity must pick one of the two offers as the OON rate; must select the offer closest to QPA, unless *credible* information demonstrates the value is *materially different*

### Required information

- Offer of OON rate expressed as dollar amount and percentage of QPA
- Any information IDR entity requests
- Provider size and specialty
- Plan coverage area, relevant geography for QPA, and funding
- QPA for applicable year for the same/similar item or service

### Optional information

- Level of training, experience and quality/outcomes measurements
- Provider's or plan's market share
- Acuity of the participant/beneficiary receiving care or complexity of the service
- Teaching status, case mix, scope of services at facility
- Good faith efforts (or lack thereof) by both parties to establish network relationship over the past four years
- Contracted rates between the parties over the past four years, if any

### Additional optional information for air ambulance services

- Training, experience and quality of medical personnel furnishing the air ambulance services
- Ambulance vehicle type and clinical capability level
- Population density at pick-up

**Prohibited information:** Usual and customary charges; public payer rate (i.e., Medicare, Medicaid, CHIP, TRICARE); provider's charge in the absence of surprise billing protections

# Surprise billing

## External review under 2015 ACA rules

Adverse benefit determination now includes whether a plan is applying cost-sharing protections to claims covered by the surprise billing rules.

**Examples include:**

- Whether cost sharing protections apply to pre-stabilization treatment in OON emergency department of hospital
- Whether cost sharing protections apply to OON anesthesiologist at in-network health care facility
- Whether claimant was in a condition to receive informed notice to waive cost-sharing and surprise billing protections
- Whether care was ancillary care for which protections cannot be waived

**Employer to do: Review claim procedures, SPDs and plan documents to determine whether revisions/amendments are required.**

# 2022 MHPAEA report to congress

**Tri-agency FAQs Part 45 (April 2, 2021)**

Identified four initial enforcement priorities:

- Prior authorization (inpatient)
- Concurrent review (in- and outpatient)
- Out-of-network reimbursement rates
- Standards for provider network admission (includes provider rates)

| CMS requests | # requested |
|---|---|
| **Concurrent care review** | 7 |
| **Provider network participation requirements** | 6 |
| **Prior authorization** | 5 |
| **Provider credentialing standards** | 2 |
| **Treatment certification requirements** | 1 |

| Most common NQTLs for which a comparative analysis was requested by DOL | Frequency* |
|---|---|
| **Preauthorization or precertification requirements** | 1 |
| **Network provider admission standards** | 2 |
| **Concurrent care review** | 3 |
| Limitations on applied behavior analysis or treatment for autism spectrum disorder | 4 |
| **Out-of-network reimbursement rates** | 5 |
| Treatment plan requirements | 6 |
| Limitations on medication assisted treatment for opioid use disorder | 7 |
| **Provider qualification or billing restrictions** | 8 |
| Limitations on residential care or partial hospitalization programs | 9 |
| Nutritional counseling limitations | 10 |
| Speech therapy restrictions | 11 |
| Exclusions based on chronicity or treatability of condition, likelihood of improvement, or functional progress | 12 |
| Virtual or telephonic visit restrictions | 13 |
| Fail-first or step therapy requirements | 14 |
| *Descending order of frequency | |

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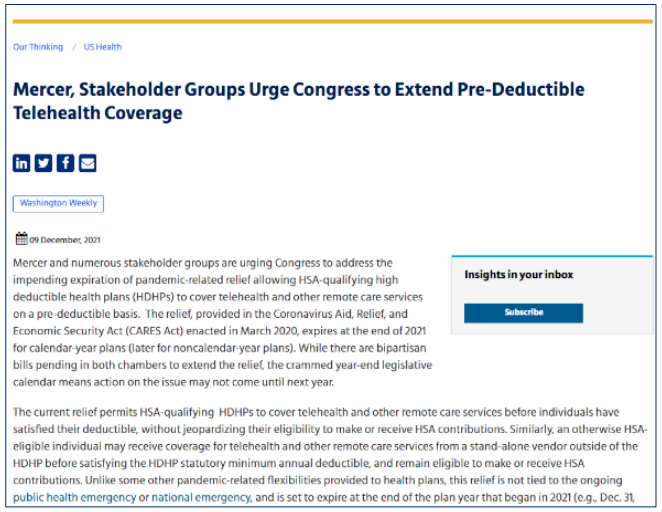

Our Thinking / US Health

**Mercer, Stakeholder Groups Urge Congress to Extend Pre-Deductible Telehealth Coverage**

Washington Weekly

09 December, 2021

Mercer and numerous stakeholder groups are urging Congress to address the impending expiration of pandemic-related relief allowing HSA-qualifying high deductible health plans (HDHPs) to cover telehealth and other remote care services on a pre-deductible basis. The relief, provided in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) enacted in March 2020, expires at the end of 2021 for calendar-year plans (later for noncalendar-year plans). While there are bipartisan bills pending in both chambers to extend the relief, the crammed year-end legislative calendar means action on the issue may not come until next year.

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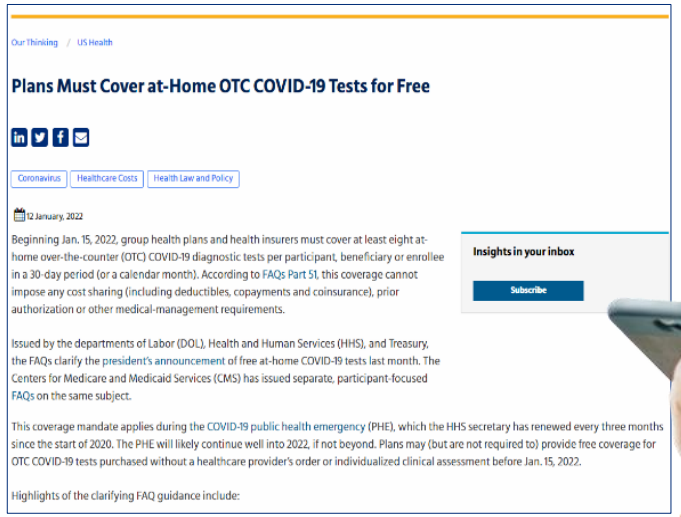
The current relief permits HSA-qualifying HDHPs to cover telehealth and other remote care services before individuals have satisfied their deductible, without jeopardizing their eligibility to make or receive HSA contributions. Similarly, an otherwise HSA-eligible individual may receive coverage for telehealth and other remote care services from a stand-alone vendor outside of the HDHP before satisfying the HDHP statutory minimum annual deductible, and remain eligible to make or receive HSA contributions. Unlike some other pandemic-related flexibilities provided to health plans, this relief is not tied to the ongoing public health emergency or national emergency, and is set to expire at the end of the plan year that began in 2021 (e.g., Dec. 31,



Our Thinking / US Health

**Plans Must Cover at-Home OTC COVID-19 Tests for Free**

Coronavirus | Healthcare Costs | Health Law and Policy

12 January, 2022

Beginning Jan. 15, 2022, group health plans and health insurers must cover at least eight at-home over-the-counter (OTC) COVID-19 diagnostic tests per participant, beneficiary or enrollee in a 30-day period (or a calendar month). According to FAQs Part 51, this coverage cannot impose any cost sharing (including deductibles, copayments and coinsurance), prior authorization or other medical-management requirements.

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Issued by the departments of Labor (DOL), Health and Human Services (HHS), and Treasury, the FAQs clarify the president's announcement of free at-home COVID-19 tests last month. The Centers for Medicare and Medicaid Services (CMS) has issued separate, participant-focused FAQs on the same subject.

This coverage mandate applies during the COVID-19 public health emergency (PHE), which the HHS secretary has renewed every three months since the start of 2020. The PHE will likely continue well into 2022, if not beyond. Plans may (but are not required to) provide free coverage for OTC COVID-19 tests purchased without a healthcare provider's order or individualized clinical assessment before Jan. 15, 2022.

Highlights of the clarifying FAQ guidance include:

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