2021 Employer Playbook

Key benefits compliance obligations for 2021, and preparations to make for 2022

Lockton Compliance Services

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Table of contents

Introduction

2021, on its own and as the runway to 2022, is the most vexing benefits compliance environment plan sponsors have ever seen. To be sure, it's the most vexing compliance environment *we've* ever seen. In addition to the usual suspects that create compliance headaches for sponsors – the Affordable Care Act, federal, state and local reporting, COBRA, HIPAA, HSAs, etc. – plan sponsors have a host of new obligations with which they must comply *this year*, and a legion of additional complex requirements to which they must give attention *this year* in order to be prepared to comply by *next year*. These obligations include:

- Cafeteria plan and flexible spending account accommodations for the 2021 and 2022 plan years
- Change to tax treatment of dependent care benefits (election amounts, carryovers, and limiting age for qualifying children)
- Outbreak period guidance (suspension of COBRA and HIPAA special enrollment election deadlines, COBRA premium payment deadlines, and deadlines for submitting claims and appeals)
- American Rescue Plan Act COBRA subsidies, and their interplay with the outbreak period guidance
- Mental health parity non-quantitative analysis
- Healthcare plan cost reporting
- Prohibition on price and quality data gag clauses
- New broker/consultant/vendor compensation disclosure requirements
- Healthcare plan online price comparison tool (2022)
- Healthcare plan "advance explanations of benefits" (2022)
- Healthcare plan online "three machine-readable files" re in-network, out-of-network and prescription drug costs (2022)
- Surprise billing requirements and protocols (2022)
- New ID cards (2022)
- New network accuracy requirements (2022)
- New "continuity of care" disclosures (2022)
- Federal, state and local paid leave and similar requirements

We have addressed these requirements ***separately*** over the past several months in a variety of alerts, blogs, webcasts, podcasts and white papers, in addition to grids, model employee communications and other documents. Here in *this* document, however, we have assembled brief summaries of these obligations ***in the aggregate***, and added "to do" lists to assist our clients not only in complying with the requirements currently in effect, but also in planning to comply with the requirements taking effect later this year or at the beginning of the coming plan year.

Outbreak period guidance

Effective date: The guidance is in effect until 60 days after the date the president rescinds the national health emergency related to COVID-19

Federal officials suspended, in an announcement dating to April 2020, the running of various benefit plan-related action periods, such as the periods for COBRA and HIPAA special enrollment elections, COBRA premium payments, and claims and appeals submissions. The suspensions were intended to apply during what that announcement called the COVID-19 "outbreak period," a period that began March 1, 2020, and runs through the 60th day following the rescission of the coronavirus-related national emergency declared or extended by the president. See our alert on last spring's announcement.

What nobody last spring foresaw was that the emergency declaration would still be in effect more than a year later. In fact, in January 2021, the Biden administration renewed the declaration for up to another year. That created additional complications because under federal law, a suspension of these plan-related action periods cannot exceed 12 months. In late February 2021, federal authorities issued additional guidance, summarized in our new alert, that generally – but not entirely adequately – explained how the maximum 12-month suspension applied, particularly in the COBRA premium payment context.

Under the most recent guidance, the suspension period for any given individual's COBRA or HIPAA special enrollment election, COBRA premium payment, or claims or appeals submission lasts until the earlier of (i) the 60th day following the president's rescission of the national emergency, and (ii) the end of the 12-month suspension period that applies to the specific deadline, under the February 2021 guidance from federal officials.

OUTBREAK PERIOD "TO DO" LIST (2021)

- Conform plan administration practices with respect to COBRA elections, COBRA premium payments, HIPAA special enrollment requests and coverage effective dates, claims and appeals submission deadlines, and the deadline for submitting or perfecting a request for third-party review of a denied medical claim, to implement the required suspension period.
  - Work with plan administration-related vendors to identify individuals affected by the outbreak period guidance and, for each affected individual (whether the individual's suspension in currently in effect or begins later), the individual's unique maximum 12-month suspension period. Adjust that maximum period as necessary to account for an earlier expiration of the suspension period upon rescission of the national health emergency.
    - Example: John voluntarily terminated employment and lost healthcare coverage on Oct. 1, 2020, and the plan sent his COBRA election notice on Oct. 25, 2020. Identify John as an individual affected by the outbreak period guidance. John's 60-day window to elect COBRA does not begin until Oct. 25, 2021, unless the outbreak period ends earlier (e.g., if the president rescinds the national emergency on June 30, 2021, the outbreak period ends on Aug. 29, and John's 60-day election window begins to run on Aug. 30, 2021).
  - Work with plan administration-related vendors to ensure that, as the 12-month maximum suspension periods expire, you and the vendor understand how each expiration will affect the remainder of the relevant period (e.g., the maximum COBRA coverage period).

- Example: Continuing the example above, John elects COBRA on Aug. 1, 2021. John's maximum COBRA coverage period, measured from the original qualifying event date in 2020, could run to as late as March 31, 2022 (because under the outbreak period guidance, while John's COBRA election on Aug. 1, 2021, is valid, the end of John's maximum COBRA coverage period does not change (i.e., the 18-month period does not begin to run from Aug. 1, 2021, but rather from Oct. 1, 2020).

  However, John needs to pay for his COBRA coverage retroactively; he does not necessarily need to come completely current in order to gain COBRA coverage retroactively, but if he does not come completely current his COBRA coverage is only in place for the consecutive months, beginning with Oct. 2020, for which he paid premium (i.e., John can't pick and choose for which prior months he wanted COBRA).

  - Note that each monthly premium payment due date and 30-day grace period is subject to its own suspension period under the outbreak period guidance.
  - Note also that this example assumes a voluntary termination of employment. If John's qualifying event had instead been a reduction in hours or involuntary termination of employment, you will need to factor in the consequence of the separate election John can make for subsidized COBRA coverage effective April 1, 2021.

- Work with the plan's insurance or stop loss carrier to determine how claims will be treated during the outbreak period to make sure appropriate claims are pended and ultimately paid (if the required premiums are ultimately paid). If necessary work with legal counsel to negotiate with and obtain assurances from the plan's insurance or reinsurance (stop loss) carrier that the carriers will treat as a covered claim any claim you determined, under your good faith application of the outbreak period guidance, to be a covered claim. It is best if this assurance is gained promptly and before any dispute arises.
- Consider notifying employees and other affected individuals (e.g., individuals who have COBRA election and coverage rights due to a COBRA qualifying events) of the suspension of relevant action periods within which they would normally have had to make an election, pay the premium, submit claims and appeals, etc. Your Lockton account team as a model notice to share with you.
- Pay particular attention to the challenging interplay between the outbreak period guidance and the new COBRA subsidies under the American Rescue Plan (ARP or ARPA). See the discussion of your obligations under ARPA in the COBRA subsidies section of this playbook, beginning on page 9.

Section 125 plan accommodations

Effective/due dates potentially vary; *generally*, calendar year section 125 plans adopting amendments relating to the *2020* plan year should be amended by Dec. 31, *2021* (see discussion below for specifics)

IRS guidance from May 2020, and the Consolidated Appropriations Act (CAA) passed later that year, offered section 125 plan sponsors a variety of options for the 2021 and 2022 plan years to address adverse consequences potentially suffered by plan participants due to COVID-19. For example, plan sponsors with flexible spending accounts are permitted to extend grace periods for up to 12 months following the close of the 2020 and/or 2021 plan years, add grace periods of similar length with respect to those plan years, and add 12-month carryover provisions (including, for the residual amounts from the 2020 and 2021 plan years, carryover provisions to dependent care FSAs).

The 2020 IRS guidance, the CAA and/or the American Rescue Plan Act (ARP, or ARPA) also permit cafeteria plan sponsors to:

- *Allow a variety of mid-year benefit election changes in calendar year 2020 and for the plan year ending in 2021, without the prerequisite "change in status" or similar events.*
- *Permit a health FSA to reimburse the cost of over-the-counter medicines and drugs, including women's menstrual products and coronavirus-related personal protective equipment, retroactive to Jan. 1, 2020.*
- *Allow health FSA participants who terminated coverage during 2020, or who terminate during 2021, to have claims incurred after termination nevertheless paid by the FSA other than on a COBRA basis.*

The CAA also temporarily increases the limiting age of a child, for purposes of dependent care FSAs, to age 14. ARPA, in a companion provision, increases the tax free limit for dependent care benefits to $10,500 ($5,250 for married individuals filing separately) for calendar year 2021, and the IRS in subsequent guidance will allow dependent care carryover amounts from 2020 and 2021 to be paid on a tax free basis during the following year if the amounts would have been considered tax free had they been paid during the year from which they were carried over.

For more on these changes in the law see our alert on the CAA, our alert on the IRS's guidance implementing the CAA's section 125 plan provisions, our alert on the IRS guidance (from May of 2021) regarding dependent care FSA benefit carryovers, and our webcast on implementing the new rules for 2021 and 2022.

SECTION 125 PLAN/FSA TO DO LIST (2021)

- Consider whether to amend health and/or dependent care FSA grace periods for plan years ending in 2020 and/or 2021 to ***extend grace periods*** up to a maximum period of 12 months following the end of the year to which the grace period will relate. If your FSAs do not currently have grace periods, consider whether to ***add grace periods*** that will apply to residual balances from the 2020 and/or 2021 plan years (the new grace periods may also be up to 12 months long).

  Where the FSA has no grace period or carryover feature, consider whether to amend the FSA to ***install a carryover feature*** relating to residual balances from the 2020 and/or 2021 plan years.

  > **Lockton comment:** Note that any benefits made available during a grace period, or via a carryover, pursuant to the CAA and subsequent IRS guidance are ignored when conducting nondiscrimination tests for 2021 and 2022.

Note also that if you are adding or extending a grace period or adding a carryover feature to a health FSA, consider the impact of the grace period or carryover feature (relating to a general purpose FSA) on participants' eligibility to accrue the right to make HSA contributions for months in which the grace period or carryover feature is in effect. There are a variety of work-arounds for this obstacle, as discussed in our alerts and webcasts. Contact your Lockton account service team.

  - An amendment to add or extend a grace period or to add a carryover feature may be adopted retroactively but should be made by the last day of the first calendar year following the end of the FSA plan year to which the amendment relates. Thus, calendar year FSAs adding or extending a grace period, or adding a carryover feature, that will apply to residual balances from the 2020 plan year should be amended by Dec. 31, 2021. A separate amendment allowing for a similar grace period of carryover from the 2021 plan year *could* be made as late as Dec. 31, 2022 (but if you are amending your FSAs to address residual balances from both years, it would make sense to amend by Dec. 31, 2021).
  - In the case of a retroactive amendment, the plan must be administered in accordance with the amendment between the retroactive effective date of the amendment and the date the amendment is made. Notify participants of any such amendment.
- Consider whether to amend your section 125 plan to permit election changes without regard to a change in status or similar event. The CAA and the IRS will temporarily (for the plan year ending in 2021) permit you to allow employees to do the following without regard to such events; you may permit one, some or all of these, and if you choose to permit one or more of these changes, you may limit the number, extent, and timing of such changes:
  - Make, revoke or modify any health and/or dependent care benefit election prospectively, for the FSA plan year ending in 2021. You may even permit an employee who had not elected to participate in an FSA for the plan year ending in 2021 to add FSA coverage retroactively to the beginning of the plan year beginning in 2021, although the employee contributions used to fund those benefits must be deducted only prospectively, following the election change.
  - Add employer healthcare coverage (medical, dental, vision) prospectively, or *change* coverage prospectively, including moving from one plan to another or changing coverage tiers (e.g., self-only to family).
  - Drop employer healthcare coverage prospectively if the employee represents that the employee has or will shortly have other comprehensive medical coverage.

    Lockton comment: Note that the IRS, in its May 2020 guidance, allowed similar accommodations related to election changes made in calendar year 2020. An amendment permitting such accommodations for *2020* must adopted by Dec. 31, 2021.
  - An amendment, allowing for these election changes, may be made retroactively, but should be adopted by:
    - As noted above, for accommodations related to election changes made in calendar year 2020 under the IRS's May 2020 guidance: by Dec. 31, 2021.
    - For accommodations related to the plan year ending in 2021: by Dec. 31, 2022. (An amendment allowing for these election changes with respect to both 2020 and the plan year ending in 2021 should, for efficiency's sake, be adopted in a single amendment by Dec. 31, *2021*.)

- In the case of a retroactive amendment the plan must be administered in accordance with the amendment between the retroactive effective date of the amendment and the date the amendment is made. Notify participants of any such amendment.

- Work with your dependent care FSA administrator and payroll department or vendor to ensure appropriate tax treatment of:
  - Benefits payable for 2020 and 2021 with respect to qualifying children who attained age 13 in 2020 or 2021
    - Under prior law, tax-free dependent care benefits were not available with respect to non-disabled children once they attained age 13. Under the CAA, however, if the employee was enrolled in a dependent care FSA for a plan year whose open enrollment period ended on or before Jan. 31, 2020, and the child attained age 13 during that plan year (or, if the employee had a residual balance in the FSA at the end of the that plan year, the child attained age 13 in the following plan year), the limiting age for the child is age 14. Note that with respect to that following plan year, the child who attains age 13 in that year is considered a qualifying child only as to the FSA residual balance from the prior year.
    - The IRS requires a plan amendment to implement this change. The amendment may be adopted retroactively by the last day of the first calendar year beginning after the end of the FSA plan year to which the amendment relates (in most cases this will be Dec. 31, 2021). If you intend to adopt such an amendment the FSA should be operated in accordance with the accommodation in the meantime, and notice provided to FSA participants.
  - Benefits elected for 2021
    - Employers may amend their dependent care FSAs to permit participants to change their 2021 benefit election from a $5,000 maximum ($2,500 for married individuals filing separately) to a $10,500 maximum ($5,250 for married individuals filing separately). Take care in this regard; allowing highly paid participants to elect such a larger amount in dependent care benefits for 2021 could trigger a nondiscrimination issue under the dependent care FSA.
    - If you adopt this amendment, it should be adopted by the last day of the calendar year beginning after the end of the plan year to which it relates (i.e., Dec. 31, 2022, for calendar year plans) and the FSA should be operated in accordance with the accommodation in the meantime, and notice provided to participants.
  - Benefits carried over from 2020 to 2021, and/or from 2021 to 2022
    - The IRS will permit dependent care benefits carried over from the 2020 plan year to the 2021 plan year, and from the 2021 plan year to the 2022 plan year, to be paid tax free if the benefits would have been tax free had they been paid in the year from which they were carried over. Note that these tax-free benefits are in addition to the $10,500 (or, as applicable, $5,250) in tax free benefits available to participants in 2021, under the CAA's provisions. This accommodation can create administrative wrinkles for non-calendar year FSAs. See our alert.
    - This accommodation should not require a plan amendment, as the taxability of these benefit payments is dictated by the federal tax code.

- Determine whether to allow your section 125 plan to pay employees' post-termination health FSA claims on a non-COBRA basis (this continuation of coverage would essentially operate as an

alternative to COBRA coverage). You may adopt this accommodation with respect to terminations that occurred in 2020 or that occur in 2021.

  - The amendment may be adopted retroactively as late as Dec. 31, 2021 (for terminations occurring in 2020; by Dec. 31, 2022, for terminations occurring in 2021). If you intend to adopt such an amendment the FSA should be operated in accordance with the accommodation in the meantime, and notice provided to FSA participants.

- Determine whether to allow your health FSA and or health reimbursement arrangement to reimburse the out-of-pocket expense for over-the-counter medicines and drugs, menstrual products and/or personal protective equipment, and if so, whether the effective date of the change will be retroactive to Jan. 1, 2020 or a later date.
  - The amendment should be adopted no later than the last day of the plan year in which the change is effective, and notice provided to participants.

ARPA COBRA subsidies

Effective date: Generally, April 1, 2021, with certain specific due dates for particular notices, as noted below

The American Rescue Plan Act (ARPA) authorizes federally-guaranteed COBRA subsidies for up to six months (from April 1 – Sept. 30, 2021, the "COBRA subsidy window") for individuals who lost employer-based group health coverage due to involuntary termination of employment, or voluntary or involuntary reduction in hours, if they're not eligible for other substantial medical coverage and their maximum COBRA coverage period extends, or would have extended had they elected COBRA (or if they elected it, had not dropped it) at least through April 2021.

For background on the ARPA COBRA subsidies, see our recent summary, and for an explanation of early guidance related to the form and timing of modified COBRA notices, to comply with ARPA, see our alert and grid, which link to DOL-issued model notices.

ARPA COBRA SUBIDY "TO DO" LIST (2021)

- Identify the plan or plans that are obligated to provide COBRA and the ARPA subsidies. In general, if the employer-based plan (other than a health flexible spending account) has a federal COBRA obligation, the employer that "maintains the plan" is responsible for sending the notices and providing the subsidy, and has the right to claim a tax credit to recoup the value of the subsidy it provided.
- Send the appropriate notices, or work with your COBRA vendor, if applicable, to ensure the appropriate notices are timely sent to those individuals who are eligible for the subsidy (referred to in ARPA as "assistance eligible individuals," or "AEIs").
  - AEIs whose COBRA qualifying event dates were prior to April 1, 2021, should receive, by **May 31, 2021**, the *Model COBRA Continuation Coverage Notice in Connection with Extended Election Periods*, plus the *Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021*. ***Note that if you click these download links, the file should download to your computer and you will then have to click the file to open it.***
    - This will require identifying those individuals who experienced requisite qualifying events, even if they did not elect COBRA (or elected it but dropped it), at least as far back as October 2019, for plans subject only to federal COBRA, and perhaps earlier for plans subject to state coverage continuation laws that may grant coverage continuation rights for more than 18 months for a termination of employment or reduction in hours (as this document went to press the IRS had not yet issued its guidance on the technical aspects, including the operation of state mini-COBRA laws, of the ARPA subsidies).
  - AEIs whose qualifying event dates occurred or occur on or after April 1, 2021, but not later than Sept. 30, 2021, should receive the *Model ARP General Notice and COBRA Continuation Coverage Election Notice*, plus the *Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021*. They should receive these forms within the normal timeframes for distributing COBRA election notices following a qualifying event. ***Note that if you click these download links, the file should download to your computer and you will then have to click the file to open it.***

  - AEIs about to lose eligibility for COBRA subsidies (either because the COBRA subsidy window is closing or the AEIs became eligible for other substantial medical coverage) should receive a *Notice of Expiration of Premium Assistance* **not more than 45 days, and not less than 15 days**, before the AEIs lose eligibility for the COBRA subsidies.
- Take steps to ensure that AEIs are not required to make premium payments for the period for which they are eligible for subsidies. If an AEI makes a premium payment for a period of COBRA coverage for which the AEI qualifies for subsidies, return the payment, or obtain the agreement of the AEI to apply the premium payment against future COBRA premiums after the AEI's eligibility for subsidies terminates.
- Upon issuance of IRS guidance on the procedures for recouping the fronting of COBRA premiums for AEIs via a refundable tax credit against Medicare hospitalization payroll taxes, follow IRS procedures to recoup that premium expense. Keep all appropriate records to demonstrate entitlement to the tax credit.

Transparency-related obligations: Overview

Both the final healthcare plan transparency regulations issued by the Trump administration in 2020 (the Final Rule), and statutory transparency requirements included in the Consolidated Appropriations Act (CAA) late that same year, impose similar cost-related disclosure obligations on group health plans. While only a portion – and not the most difficult portion – of the Final Rule's obligations take effect in the plan year beginning in 2022, all of the key CAA disclosure obligations take effect for that plan year. Unfortunately, the CAA describes several of its disclosure obligations only in the most general of terms, and thus the mechanics of complying with those obligations will have to be fleshed out in regulations.

The plan (and therefore by extension the plan sponsor) is ultimately responsible for complying with these requirements. The plans' ability to comply will depend on access to, and the means to disclose, information currently not in the plan's possession or under its control. Various vendors – insurers, third-party administrators, pharmacy benefit managers, etc. – have the information and are better equipped to disclose it. Thus, sponsors must rely on these vendors to comply with these requirements.

Therefore, plan sponsors will want to engage legal counsel to negotiate modifications to all relevant contracts with those vendors that involve services implicating the transparency requirements, to ensure that the plan sponsor can timely satisfy its transparency obligations, via the mandated methods, to participants and other interested parties. See **Appendix I** for sample language that might serve as a *potential starting point* for these negotiations.

> **Lockton comment:** Insurers may be unable to modify insurance contracts because the contracts are filed with state authorities. Consider negotiating separate memoranda of understanding with insurers, but be sure that language in the contract providing that it is the "entire agreement" between the parties does not nullify a separate agreement. Legal counsel can be helpful here.

A general description of the CAA's and Final Rule's transparency obligations falling due in 2022 appears in the table below. These obligations were extensively explored in our February 2021 webcast.

Requirement	Source	Effective date
Price comparison tool	CAA	Plan years beginning in 2022
Advance explanation of benefits	CAA	Plan years beginning in 2022
Public, online disclosure of in-network rates, out-of-network allowed amounts, and Rx pricing	Final Rule	Plan years beginning in 2022
Accurate network directory information	CAA	Plan years beginning in 2022
Prohibition on price/quality gag clauses	CAA	In effect
Report plan cost information	CAA	Dec. 27, 2021, and June 1 annually thereafter
Report broker/consultant/vendor comp.	CAA	Contracts made/renewed on or after Dec. 27, 2021
Issue ID cards reflecting required cost-sharing information	CAA	Plan years beginning in 2022
Continuity of care disclosures	CAA	Plan years beginning in 2022

Transparency: Price comparison tool

Effective for plan years beginning on or after Jan. 1, 2022

The CAA requires group plans to make available a price comparison tool, by telephone and internet site, that allows an enrollee to compare the amount of cost sharing (deductibles, copayments, coinsurance, etc.) the enrollee would incur with respect to a specific item or service.

*This requirement is substantially similar to a cost disclosure obligation under the Final Rule that takes effect for plan years beginning in **2023**. The chart below summarizes the two similar requirements; we show the Final Rule's requirements, effective a year after the CAA's requirements, because we suspect regulators will impose similar requirements in regulations they will issue under the CAA, conflating the two sets of requirements and effectively accelerating the due date for compliance with the Final Rule. As a result, plan sponsors will want to consider the Final Rule's requirements in planning for 2022.*

Price comparison tool	
CAA[1] – plan years beginning in 2022	**Final Rule – plan years beginning in *2023***
A group health plan must offer price comparison guidance by telephone, and make available on the plan's internet website, a price comparison tool that allows an enrollee, taking into account the geographic region and participating providers, to compare the amount of cost sharing that the individual would be responsible for with respect to the furnishing of a specific item or service by any such provider.	The Final Rule requires group health plans to disclose cost-sharing information for 500 healthcare services or items upon the request of an enrollee (or authorized representative, including a healthcare provider) through an internet-based, self-service tool or, upon request, in paper form. The disclosure must include the following elements and be accurate at the time of the request: • Accumulated cost-sharing amounts incurred to date (e.g., deductible, out-of-pocket limits, etc.) • The in-network rate for the relevant service or item • The out-of-network allowed amount or other rate that yields a more accurate estimate of an amount the plan will pay for the service or item • If the item or service is subject to a bundled arrangement, a list of the items or services for which cost-sharing information is being disclosed • Notice of any applicable prerequisite (e.g., concurrent review, prior authorization, step-therapy, etc.) • A notice to be articulated by regulators. The information must be made available through a free, internet-based self-service tool through which users may search for cost-sharing information for a covered service or item and with respect to specific in-network providers (or by all in-network providers), and the out-of-network allowed amount. The information must be findable by inputting: • A billing code or descriptive term • The name of the provider (for in-network providers) • Any other factors used by the plan to determine cost-sharing amounts

[1] The CAA's rules are contained in section 114 of subtitle BB of that Act.

PRICE COMPARISON TOOL "TO DO" LIST (2021, IN PREPARATION FOR 2022)

- Identify the electronic posting requirements and actions needed to comply with the price comparison tool requirements. The necessary information is likely controlled by plan-related vendors. Therefore, the plan will need to negotiate with the appropriate party regarding the posting of that information.
- When necessary, engage with legal counsel to negotiate with the vendor regarding establishing the internet website and populating it with the required data. The plan sponsor should attempt to obtain a contractually binding indemnification provision to protect the plan and plan sponsor in the event the vendor fails to meet its obligations under the contract. Some important contractual elements to consider include:
  - Where the site will be hosted and how access will be granted
  - How the vendor will host data on the site
  - The cost imposed by the vendor for its cooperation
  - How the contractually responsible party will satisfy the internet site's obligation to comply with federal requirements as to:
    - Accuracy of relevant information
    - Timeliness
    - Integration into plan design
    - Data integration with other relevant plan vendors
    - Search engine requirements

Transparency: Advance explanation of benefits

Effective for plan years beginning on or after Jan. 1, 2022

The CAA provides that group health plans, after receiving a notification from a plan enrollee, the enrollee's authorized representative or a healthcare provider that the enrollee is scheduled to receive care from the provider, must provide the enrollee with an "advance explanation of benefits" (Advance EOB) reflecting what the plan can be expected to pay and the enrollee's anticipated cost-sharing amount. Generally, this Advance EOB is due within three business days after the request. However, if the request is made by the provider or the enrollee's authorized representative and the care was scheduled to be delivered less then10 business days after scheduling, the plan must supply the Advance EOB within one business day after the request.

This Advance EOB must indicate:

- *The provider's network status, and if in-network, the contracted rate for the service (if out-of-network, a description of how the individual can obtain a list of in-network providers*
- *An estimate of what the plan will pay the provider*
- *An estimate of the enrollee's cost-sharing responsibility*
- *An estimate of the plan's cost-sharing requirements the enrollee has met to date*
- *If the service is subject to medical management techniques (e.g., prior authorization, step therapy, etc.), a notice that the service is subject to such a requirement*
- *That the information in the Advance EOB is only an estimate and subject to change*

ADVANCE EOB "TO DO" LIST (2021, IN PREPARATION FOR 2022)

- Identify those tasks required by the Advance EOB requirements that the plan sponsor will not be able to accomplish without the assistance of vendors, and work with legal counsel to negotiate what the vendors will agree to handle on behalf of the plan sponsor. Request indemnification of the plan and plan sponsor for any violations arising from the vendor's failure to comply with any obligations they agree to assume on behalf of the plan/plan sponsor.
- Negotiate any costs associated with any activities undertaken by the vendor to help the plan satisfy the Advance EOB requirements. In this regard, identify and negotiate reasonable limits on any costs the vendor intends to charge for its own, or a third-party sub-vendor's, efforts to assist the contracting vendor in helping the plan/plan sponsor satisfy its obligations.
- Ensure the plan can effect data integration with vendors that maintain the information required by the plan and integrate a search engine and relevant parameters if the Advance EOB will be generated via an online tool; the platform must be capable of providing a paper document if requested, and must be able to archive the advance EOBs generated by the plan.

Transparency: Public, online disclosure of in-network rates, out-of-network allowed amounts, and Rx pricing

Effective for plan years beginning on or after Jan. 1, 2022

The Final Rule requires plans and insurers to disclose via a publicly available website and three machine-readable files: (1) The in-network rates for each service or item covered by the plan, (2) historical billed charges from out-of-network providers and the amount of such charges considered allowed amounts by the plan, and (3) prescription drug pricing information. The plan must update these monthly and cannot impose a fee to access the information. Information must be available without requiring a user to log in or provide any credentials. For example, the plan cannot require someone to register or create an account in order to gain access to the information.

More details on the elements of these machine-readable files is reflected in ***Appendix II.***

This requirement applies to non-grandfathered plans but not to health reimbursement arrangements and other account-based plans or to excepted benefits (e.g., most health flexible spending accounts, dental plans and vision plans).

PUBLIC ONLINE DISCLOSURE OF PLAN COSTS "TO DO" LIST (2021, IN PREPARATION FOR 2022)

- Identify the electronic posting requirements and actions needed to comply with the public online disclosure requirements. The necessary information is likely controlled by plan-related vendors. Therefore, the plan will need to negotiate with the appropriate party regarding the posting of that information.
- When necessary, engage with legal counsel to negotiate with the vendor in establishing the internet website and populating it with the required data. The plan sponsor should attempt to obtain a contractually binding indemnification provision to protect the plan and plan sponsor in the event the vendor fails to meet its obligations under the contract. Some important contractual elements to consider include:
  - Where the site will be hosted and how access will be granted
  - How the vendor will host data on the site; again, see **Appendix II** for a summary of specific content elements
  - The cost imposed by the vendor for its cooperation
  - How the contractually responsible party will satisfy the internet site's obligation to comply with federal requirements

Transparency: Updated network provider directory requirements

Effective for plan years beginning on or after Jan. 1, 2022

The CAA requires plans to ensure their provider directories are accurate and can be accessed online or via telephone. The plan must have a process for auditing, every 90 days, the accuracy of the provider information in the directory, must remove a provider from the directory if the plan cannot verify the provider's network status, and otherwise update the directory within two business days of discovering its inaccuracies.

If a participant requests verification of a provider's in-network status over the telephone, the plan must reply in writing (the enrollee can agree to accept e-notification) within one business day. The plan must maintain a record of the enrollee's request and the plan's reply for at least two years. The plan must also maintain on its website a list of providers with whom the plan has a direct or indirect contractual relationship, and each provider's name, address, specialty, phone number and digital contact information. If the plan's provider directory information is incorrect and an enrollee relies on the information to their detriment, the enrollee can only be charged the in-network cost-sharing amount.

UPDATED NETWORK PROVIDER DIRECTORY REQUIREMENTS "TO DO" LIST (2021, IN PREPARATION FOR 2022)

- Negotiate or, where applicable, work with legal counsel to negotiate the following matters with the relevant vendor, and request contractual indemnity for the vendor's failures:
  - Where the directory will be hosted (e.g., carrier/TPA/other vendor website or other location)
  - The obligation to keep the directory up to date and accurate
  - The existence of protocols to ensure timeliness of updates (i.e., all information is reviewed every 90 days and when providers leave the network, the directory must be updated within two business days)

Transparency: Prohibition on price and quality data "gag clauses"

Effective currently

The CAA prohibits group health plans from entering into contracts with certain entities if the contract would restrict the plan's access to (and ability to share) price and quality information. Specifically, the Act prohibits plans from entering into contracts with healthcare providers, networks or associations of providers, third-party administrators, or other plan-related vendors that offer access to provider networks, if the contract would directly or indirectly restrict the plan from:

- *Providing provider-specific cost or quality of care information, through a consumer engagement tool or any other means, to providers, the plan sponsor, plan enrollees or to individuals eligible for coverage under the plan*
- *Electronically accessing, upon request, coverage information or de-identified claims information for each plan participant to the extent allowed by HIPAA, the Genetic Information Nondiscrimination Act, or the Americans with Disabilities Act; the information plans must have access to include (in a per-claim or aggregate basis) financial information, such as the allowed amount or other claim-related financial obligations included in the provider contract, provider information, service codes or any other data element included in healthcare transactions leading to a claim for benefits*

In addition, the contract may not restrict the plan's right to share such information with a HIPAA business associate.

THE GAG CLAUSE PROHIBITION "TO DO" LIST (2021)

- Work with legal counsel to:
  - Determine whether any existing or impending plan-related contracts with any healthcare providers, networks or associations of providers, third-party administrators, or other plan-related vendors that offer access to provider networks contain restrictive language preventing the plan from sharing the kinds of information described above. If contracts currently in effect restrict the plan from disclosing such information, these provisions must be removed.
  - Require the vendor, to the extent required by federal law, to attest at the appropriate time and in the appropriate manner (as may be required by federal authorities) that it has not placed restrictive clauses on any medical provider.

Transparency: Report plan cost information to the federal government

Effective Dec. 27, 2021 (first report due then, unless delayed by federal regulators; subsequent reports due each June 1)

The CAA requires group health plans to report a variety of plan-related cost information. Although reporting details will be fleshed out later in federal guidance, the CAA provides that the plan is required to report the following (generally speaking):

- *The beginning and end dates of the plan year*
- *The number of participants and beneficiaries*
- *Each state in which the plan or coverage is offered*
- *Prescription drug costs including the following information:*
  - *The top 50 most frequently dispensed brand-name prescription drugs and the number of claims paid for each drug within this list; the top 50 most costly prescription drugs with respect to the plan for the year and total amount spent by the plan for each drug on this list; and the top 50 prescription drugs with the greatest increase in plan expenditures over the current plan year compared to the previous plan year. This year-over-year cost comparison must be reported aggregately as well as individually for each drug on this list*
  - *Total prescription drug spending; costs must be broken down by amounts paid by the health plan and amounts paid by plan participants*
  - *Amounts paid for therapeutic classes of drugs, and amounts paid for each of the 25 drugs that yielded the highest amount of rebates or other remuneration from drug manufacturers for the plan year*
  - *Any impact on premiums or out-of-pocket costs because of drug manufacturer rebates, fees or any other remuneration paid by drug manufacturers to the plan or its administrators or service providers*
- *Total spending on healthcare services by the plan broken down by the following types:*
  - *Hospital costs, healthcare provider and clinical services costs separated into primary care and specialty care, the average monthly premium paid by the employer on behalf of all plan participants, and other medical costs including wellness services*

THE HEALTHCARE PLAN COST REPORTING "TO DO" LIST (2021)

- Identify the plan-related vendors that have information the plan does not have but which the plan will require to adequately make required reports to federal authorities.
- Work with legal counsel to negotiate with any relevant insurance carrier, TPA and/or other plan-related vendors to ensure the plan sponsor can timely obtain the information it will need to satisfy the reporting obligation, and request contractual indemnity for the carrier's, TPA's and/or other vendor's failures to accurately and timely supply the information.

Transparency: Broker/consultant/vendor compensation disclosure

Effective for contracts executed or renewed on or after Dec. 27, 2021

The CAA requires that vendors providing brokerage or consulting services to an ERISA group health plan (including dental and vision plans) are required to disclose to plan fiduciaries, in writing, direct and indirect compensation in excess of $1,000. In turn, ERISA plan fiduciaries must require this detailed compensation information from service providers providing brokerage and consulting services.

"Brokerage or consulting services" is defined broadly to include any of the following services: selection of insurance products (including dental and vision), recordkeeping services, medical management, benefit administration, stop loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third-party administration services, development or implementation of plan design, insurance or insurance product selection.

Affected vendors must disclose to the responsible plan fiduciary at least the following information:

- *Description of services provided to the plan*
- *A statement reflecting the vendor will serve as a fiduciary of the plan (if applicable)*
- *Description of all expected direct and indirect compensation[2] the vendor expects to receive related to its services provided to the plan, including:*
  - *Vendor incentive payments and any other indirect compensation arrangements*
  - *Identity of the entity paying the compensation and the services performed that produced the compensation*
  - *Any transaction-based compensation (e.g., commissions, finder's fees) and the payer and payee*
  - *Compensation related to the contract's termination*
  - *Detail regarding how any prepaid amounts will be calculated and refunded upon termination*

The vendor must provide the compensation disclosure sufficiently in advance of entering into, amending or extending the contract for services that the fiduciary may review it to determine if compensation is reasonable.

The disclosure must include all direct and indirect compensation that is reasonably expected to be paid to the vendor, an affiliate or a subcontractor. Compensation terms may be expressed as a monetary amount, formula, or a per capita charge for each enrollee, or other reasonable method. If the contract includes conditional compensation, the disclosure must include a description of the circumstances which may generate additional compensation and the methodologies and assumptions on which the service provider will rely to calculate the additional compensation amounts.

[2] Indirect compensation includes compensation from any source other than the plan, plan sponsor, service provider or affiliate.

The vendor must alert the plan to any change to the compensation information as soon as practicable, but generally not later than 60 days after the vendor identifies the change. Plan sponsors may request additional compensation information in writing.

In the event a vendor fails to make the required disclosures within 90 days of a written request, the plan fiduciary must notify the Department of Labor via a method to be determined by the federal government, and must consider terminating the contract.

BROKER/CONSULTANT/VENDOR COMPENSATION DISCLOSURE "TO DO" LIST (2021)

- Identify the brokers, consultants and other plan-related vendors who must report such compensation to the plan, and from which plan fiduciaries must require such disclosure.
- Work with legal counsel to ensure contracts with such brokers, consultants and other vendors require these entities or individuals to make the required disclosures, including all data elements, and request contractual indemnity for their failure to timely and accurately provide such information.

Transparency: Distribute ID cards compliant with new disclosure requirements regarding cost-sharing obligations

Effective for plan years beginning on or after Jan. 1, 2022

The CAA requires group health plans to disclose, on any physical or electronic plan document or insurance identification card issued to a plan enrollee, the enrollee's applicable deductible and out-of-pocket maximums, and the telephone number and internet website address where the enrollee may receive assistance, such as information related to hospitals and urgent care facilities that have a contractual relationship (e.g., in-network status) with the plan to provide services.

UPDATED ID CARD "TO DO" LIST (2021, IN PREPARTION FOR 2022)

- Identify the party that provides enrollees with ID cards (presumably the carrier or third-party administrator (TPA)).
- Identify the party that has and will provide the cost-sharing details necessary to populate the new ID cards (again, presumably the carrier or TPA).
- Determine the manner in which the cards will be provided (e.g., hard copy, electronic, or both).
- Work with legal counsel to negotiate with the relevant TPA, insurer or other entity to ensure it will prepare and timely distribute compliant ID cards, and request contractual indemnity for the TPA's or insurer's failure to accurately and timely supply the information.

Transparency: "Continuity of care" disclosures

Effective for plan years beginning on or after Jan. 1, 2022

The CAA requires group health plans or their insurers to notify individuals who are "continuing care patients" if their treating provider has a change in network status or the plan is terminating the network relationship. Also, the plan must provide the option for the individual to continue receiving care with the medical provider at the in-network rate for an additional 90 days.

"Continuing care patients" are those: undergoing a course of treatment for a serious and complex condition; undergoing a course of institutional or inpatient care; scheduled to undergo nonelective surgery or post-operative care from the provider; are pregnant and undergoing treatment; or are terminally ill. A serious and complex condition means an acute illness that is serious enough to require specialized medical treatment to avoid death or permanent harm, or a life-threatening, degenerative, potentially disabling, or congenital chronic illness that requires specialized care over a prolonged period of time.

CONTINUITY OF CARE DISCLOSURE "TO DO" LIST (2021, IN PREPARATION FOR 2022)

- Work with legal counsel to negotiate with the plan's third-party administrator or insurer regarding the obligation to timely provide the continuing care notices, and request contractual indemnity for a failure to accurately and timely supply the disclosures (or the information necessary to allow the plan sponsor to provide the disclosures). Specific topics for negotiation include:
  - The entity that will determine in a timely manner when a network provider ceases to be part of the network.
  - The entity that will identify the continuing care patients affected by the network change of a provider.
  - The entity that will notify a "continuing care patient" in the event the patient's treating in-network provider is losing in-network status due to a contract termination or plan change.
  - The entity that will notify affected individuals of the opportunity to request transitional care and allow them to elect to continue care with the provider at in-network rates for an additional 90 days. Any such notice should also include the date on which the individual will no longer be a continuing care patient with respect to their current medical provider.

Mental health parity: Nonquantitative limits comparative analysis

Effective currently; medical plans must be prepared to provide analysis to the DOL upon request

The Consolidated Appropriations Act (CAA), passed in late December 2020, reemphasized federal authorities' concern that many medical plans might not be compliant with federal mental health parity rules, particularly with respect to nonquantitative treatment limitations, such as preauthorization requirements, policies under which amounts payable are determined, and the like. Although federal authorities had, even prior to the CAA, authority to require medical plans to prove compliance with mental health parity rules, the CAA hard-wired into federal law an obligation on the part of plan sponsors to have conducted a parity analysis and have it available, to produce to federal auditors on demand.

> ***Lockton comment:*** *Although federal authorities continue to emphasize compliance with mental health parity rules, they have been slow to provide definitive guidance on precisely how to run that analysis, at least with respect to nonquantitative treatment limits. Lockton is preparing a mental health parity compliance tool, available this summer, to help guide you through an analysis of your plan, applying what we think are reasonable parameters.*

MENTAL HEALTH PARITY ANALYSIS "TO DO" LIST (2021)

- Request from the plan's insurance carrier or third-party administrator (TPA) a review and comparative analysis of the medical plan's written and operationally imposed ***non-quantitative treatment limitations (NQTLs)*** the plan applies to mental health and/or substance abuse benefits, and any similar standards applied to comparable medical/surgical benefits. If the carrier or TPA is unable to provide the analysis, conduct the analysis on behalf of the plan, working with the carrier or TPA.
  - In that latter case, your legal counsel or Lockton account service team may be able to assist you in working with your insurance carrier or TPA to identify any NQTLs, ***described in the plan documents***, that are applied to mental health and/or substance abuse benefits. Do the same for NQTLs, if any, applied to medical/surgical benefits.

    Lockton comment: For Department of Labor (DOL) examples of NQTLs see:

    - DOL Self-compliance tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)
    - DOL FAQS about mental health and substance use disorder parity implementation and the Consolidated Appropriations Act
    - Lockton Benefits Insight & Guidance: What (might be) wrong with your mental health/substance abuse benefits
    - Lockton alert: Feds update mental health and substance abuse parity guidance
- Most importantly, work with your insurance carrier or TPA to identify ***internal policies, processes, and procedures*** used in the actual adjudication of mental health and/or substance abuse benefits, where the policies, processes or procedures operate as an NQTL on those benefits *in operation* (e.g., policies under which medical necessity determinations are made, or geographical limitations affecting the determination

of allowed amounts are imposed). Do the same for NQTLs applied *operationally* with respect to the adjudication of medical/surgical claims.

Lockton comment: This effort to identify relevant NQTLs imposed by the plan will require carrier or TPA involvement, particularly with regards to any underlying plan policies, processes and procedures under which claims are adjudicated operationally. Plan sponsors are rarely aware of the administrative policies, processes and procedures utilized in the actual adjudication of claims, but it is here, in the manner in which claims are adjudicated, and not so much on the face of the plan's written terms, that NQTL-related mental health parity violations occur.

- Work with the carrier or TPA to identify other relevant factors, including medical evidence and/or other resources, justifying the application of NQTLs, particularly in the adjudication of mental health/substance abuse claims. For example, national accreditation standards or medical expert reviews supporting the use of an NQTL, or applicable state or local laws impacting the treatment and payment of certain mental health and/or substance abuse benefits.
- Conduct a ***comparative analysis*** for each identified NQTL applied to mental health/substance abuse benefits versus similar limitations and/or requirements applied to medical/surgical benefits. This comparative analysis *should* show that the NQTLS applied to mental health/substance abuse benefits are comparable to and applied no more stringently than similar NQTLs applied to medical/surgical benefits in each relevant benefit classification (e.g., inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care and prescription drugs).

  Lockton comment: The plan will almost certainly need the assistance of the carrier or TPA in making this analysis. Some employer plan sponsors may choose to engage legal counsel to assist with plan review and comparative analysis of mental health and/or substance abuse benefits, especially if carriers or TPAs are unwilling to assist.

  – Document and retain the specific findings and conclusions of the analysis reflecting compliance with the mental health parity rules regarding NQTLs.

Surprise medical billing limitations and settlement process

Effective date: The first plan year beginning on or after Jan. 1, 2022

The CAA took aim at surprise medical billing, otherwise known as "balance billing," a rampant practice that often leaves members of a group health plan with exorbitant medical bills as a result of (often incidentally) receiving services from an out-of-network provider. The No Surprises Act, part of the CAA, generally requires that, in situations where the patient had no meaningful opportunity to choose an in-network provider, group health plans must limit the patient's cost sharing to what the patient would have paid if the service had been provided by an in-network provider, and cannot impose requirements or restrictions (e.g., prior authorization) that would not be applied to in-network services.

Then the plan and the provider engage in negotiations, and ultimately even arbitration, to settle what the plan will pay the provider. For group health plans (and specifically self-funded plans), this means that out-of-network expenses may be higher beginning in the 2022 plan year, and those plans that did not cover any out-of-network expenses in 2021 may be required to cover some out-of-network care beginning in 2022. For more on the impact of the surprise billing legislation on group plans and their sponsors, see our alert on the CAA, and specifically the alert's Appendix A.

SURPRISE BILLING "TO DO" LIST (2021, IN PREPARATION FOR 2022)

- Discuss with your insurance carriers, third-party claims administrators (TPAs) and other relevant entities the steps they are taking and processes they are implementing to meet the surprise billing requirements and the role they expect plan sponsors to play in that process.
- Discuss with your insurance carriers, TPAs and other relevant entities the steps they are taking and processes they are implementing to ensure that the manner in which the patient's cost sharing will be calculated, for claims covered by balance-billing protections, comply with the CAA or other applicable law, and determine what steps the carrier or TPA will take when issuing explanations of benefits (EOBs) to ensure that the patient's cost-sharing obligation is accurately reflected on the EOB.

  Lockton comment: Generally, and for your information, one of the following can be considered the appropriate cost-sharing amount:

  - *Where state insurance law imposes surprise billing protections:* The amount determined under state law. As noted above, this will typically be the case only with respect to insured plans, and perhaps self-funded governmental plans, subject to state insurance laws providing for surprise billing protections.
  - *Where the plan is insured and the insurance contact applies an "All Payer Model Agreement"*: The predetermined cost under the Agreement. Currently only insured plans in Maryland and Vermont apply the Agreement.
  - *The CAA's surprise billing rules:* If no state law applies (which will typically be the case where the major medical plan is self-insured), cost sharing is calculated using the median in-network amount paid by all plans of the plan sponsor for similar items or services in the prior year, plus a cost of living adjustment.

- Particularly where your major medical plan is self-insured at least in part, work with legal counsel to negotiate necessary modifications to TPA contracts, carve-out pharmacy and similar contracts, as necessary, to identify the roles the plan sponsor and the other entities will play in meeting the CAA's requirements, particularly with respect to:
  - The CAA's timeline allowing ***30 days*** for the plan and the out-of-network provider to negotiate and agree upon appropriate reimbursement before demanding arbitration; determine how will you coordinate with the TPA or other relevant party to determine the nature and extent of the negotiations.
  - The CAA's tight window to request arbitration if no agreement can be reached; determine what events will trigger the plan's demand, if any, for arbitration (likely, however, it will be the provider who typically demands arbitration where the plan does not offer a payment amount acceptable to the provider).
  - Who at the plan sponsor or TPA (or some other entity) will have authority to determine the settlement offer the plan will present at arbitration, who will be responsible for conducting the arbitration on behalf of the plan, what will that cost, and how this will be coordinated between the plan sponsor and the TPA or other relevant entity.
- For self-funded plans, engage your stop loss carrier and review the stop loss contract to ensure that arbitration awards are considered by the reinsurer as legitimately covered expenses under the plan.
- Work with legal counsel to negotiate indemnification terms and liability where the insurance carrier, the TPA or other relevant entity undertakes to ensure the plan's compliance with relevant surprise billing requirements but fails to fulfill those obligations.

Note: Federal authorities are expected to issue guidance on the CAA's surprise billing requirements sometime during the summer of 2021.

HR Compliance Consulting: Paid leave and vaccine requirements

Effective date: Various

Even before COVID-19, states and political subdivisions of states (counties, cities, etc.) were, with increasing prevalence, enacting paid sick and/or family leave laws, to the chagrin of multistate employers who were left to grapple with patchwork paid leave requirements. COVID-19 doubled down on the complexity, as many of these same jurisdictions – and some that had not yet ventured into the paid leave waters – passed laws and ordinances imposing new or additional leave-granting obligations on employers, related to the pandemic.

FEDERAL, STATE AND LOCAL PAID AND UNPAID LEAVE LAWS, AND VACCINE MANDATES, "TO DO" LIST (2021)

- Employers will want to work with legal counsel, Lockton's Integrated Absence Solutions practice, and/or Lockton's HR Compliance Consulting practice to consider the following, currently and going forward:
  - Leave laws (other than COVID-19-related laws)
    - Review applicable state-paid family and medical leave laws. See this chart for the current status of the various laws (current as of January 2021).
    - Determine the applicability of state and/or local paid sick leave laws and review corporate practices for compliance. See our alert on the California 2021 COVID-19 Supplemental Paid Sick Leave law.
    - Review the applicability of unpaid leave laws including the federal FMLA and state family and medical leave laws. A webcast on the FMLA is available here.
  - Leave laws (COVID-19 related)
    - Determine the applicability of state and local COVID-19 paid sick leave laws.
    - Determine the employer's eligibility to provide Emergency Paid Sick Leave and Emergency Paid Family and Medical Leave and recoup the expense via federal tax credits, under the American Rescue Plan Act of 2021.
  - Employment-based vaccine program
    - Determine whether to have an employment-based program related to the COVID-19 vaccine. If so, will the program:
      - Be voluntary? If voluntary, will the employer offer incentives?
      - Be mandatory?
        - Take into account that some employees may be entitled to an accommodation under the ADA or Title VII in the event there is a medical reason for not being vaccinated or religious objection to the vaccine.
        - Determine whether any state or local legislation my prohibit mandatory vaccine programs or afford employees additional protections in the workplace against discrimination for not being vaccinated.

- Be sure to accommodate employees who should not, cannot or otherwise have a legitimate (protected) reason for not obtaining the vaccine.

  - See Lockton's COVID-19 Vaccine Employer Checklist for additional information.

- Workplace policies
  - If the employer will allow for remote work or flexible work, ensure policy parameters are reduced to writing. See Lockton's Return to Work Site Toolkit.
  - Ensure anti-harassment and anti-discrimination policies address all protected categories, as state and local laws are broader than the federal counterparts.
    - Include an ADA accommodation process and ensure there is reference to a religious accommodation process.
- Training
  - Review state-imposed training compliance rules, and conduct training accordingly.
  - Conduct mandatory sexual harassment prevention training.
  - Assess and execute on measures planned in 2021 and beyond to enhance diversity and inclusion.
- Wage and hour
  - Confirm wage statement compliance.

Appendix I

Transparency Rules - Sample amendment to vendor service agreement or contract.

*This document is a sample that can be the **starting place** for a discussion with plan vendors (insurers, third-party administrators (TPAs), etc.) regarding their responsibility to assist employer plans with respect to the plans' compliance with the new rules on health plan transparency. Please discuss with legal counsel the specifics of your plan and the terms of any agreement such as this document before using. In the event that a carrier indicates that it is unable to amend its actual insurance contract, this document can serve as memorandum of understanding or other ancillary agreement that does not change the underlying terms of the insurance contract, but does serve as a contractual understanding between the carrier and the plan.*

[Choose one]

> *[For self-funded plans, or insured plans where the carrier is willing to modify the group insurance contract]* This document is an amendment to the ____ *[choose one:* agreement, contract *or insert other name or description of the agreement between the plan/plan sponsor and the vendor]* between *[insert plan sponsor name]* on behalf of the *[insert name of plan(s)]* (individually or collectively, "Plan") and *[insert name of vendor]* with respect to services provided by *[insert name of vendor]* to the Plan.
>
> *[For insured plans, where carrier asserts it cannot modify the insurance contract]* This document is a memorandum of understanding between the undersigned insurance carrier and the undersigned Plan or Plan Sponsor, regarding the matters addressed herein. This document supersedes any provision in any related insurance contract providing that the terms of such contract reflect the sole obligations and understandings of the parties thereto.

_____ *[insert name of the entity offering the plan]* the "Sponsor" and _____ *[insert name of vendor]* ("Vendor") previously entered into an agreement for the provision of group health insurance and/or healthcare claims administration services *[or insert other description]*, dated _____ (the "Agreement"), that provides for the Vendor to provide group health insurance or claims administration, or both, for one or more of the Sponsor's group healthcare plans (collectively, the "Plan"). Due to recent changes in transparency and disclosure obligations governing the Plan, the services necessary for the continued compliant administration of the Plan have changed.

Now therefore, the Agreement is hereby amended by adding the following provision *[for insured plans where the carrier asserts it cannot modify the insurance contract:* the Agreement is supplemented by the following Memorandum of Agreement*]*:

Notwithstanding anything in the Agreement to the contrary, Vendor and Sponsor agree to the following changes to the Agreement:

1. Subject to the limitation described below, Vendor agrees to provide, on behalf of the Plan, all applicable services, publication of information and other disclosures (collectively, "the Disclosures") necessitated by the Plan's obligation to meet the requirements of the price transparency mandates for group health plans and health insurance issuers set forth in 26 CFR Part 54 [TD 9929], 29 CFR Part

2590, and 45 CFR Parts 147 and 158 (the "Transparency Regulations") and the Consolidated Appropriations Act, 2021, Divisions BB and EE, amending the Public Health Service Act, the Internal Revenue Code, and the Employee Retirement Income Security Act ("CAA Transparency Provisions"), and regulations interpreting or implementing those provisions. Notwithstanding the foregoing sentence, the Vendor shall have no obligation to make the Disclosures if Vendor is not the party that is providing those services to the Plan. For example, if the Vendor is the group insurance provider, the Vendor will meet the requirements that pertain to the group insurance but if the pharmacy benefits are carved out, the Vendor will not be required to meet the requirements relative to the pharmacy benefits.

Vendor shall supply such services, make such Disclosures on behalf of the Plan in the manner and by the time set forth in the Transparency Regulations and the CAA Transparency Provisions.

Vendor hereby agrees to indemnify and hold the Plan and the Sponsor harmless from any cost, including reasonably attorneys' fees, and penalty associated, directly or indirectly, with any failure by Vendor to timely and adequately make the Disclosures.

For fully insured plans: Vendor is providing health insurance coverage for the Plan. Pursuant to this Amendment, the Vendor hereby agrees to make the Disclosures contemplated under the Transparency Regulations and CAA Transparency Provisions and thereby accepts that obligation on behalf of the Plan.

2. It is the sole responsibility of Vendor to make the Disclosures in compliance with all applicable federal standards both as to form and as to time. Any conflict or apparent conflict between the Transparency Regulations and the CAA Transparency Provisions affecting or potentially affecting one or more Disclosures shall be resolved by the Vendor in its discretion, such interpretation subject to the indemnification provisions of paragraph 1 above.

3. To the extent any obligation of the Transparency Regulations or the CAA Transparency Provisions requires additional filing or approval from any state or other jurisdictional governing agency (for example, a state department of insurance or the equivalent) the Vendor will be solely responsible for any such filing or obtaining such approvals.

Plan [Sponsor on behalf of the Plan] _____ Date _____

By_____

Vendor _____ Date _____

By_____

Appendix II

Additional details regarding the electronic disclosure of machine-readable files

Group health plans and health insurance issuers must make available on a publicly available internet website three machine-readable files related to the health plan that include the following information for covered items and services:

- In-network rates (the "In-Network Rate File")
- Historical allowed amount data (the "Allowed Amount File") and
- Prescription drug pricing information (the "Prescription Drug File")

Plans must update this information monthly.

Files must be available free of charge, without having to establish a user account, password, or other credentials, and without having to submit any personal identifying information such as a name or email address.

Specific content elements must be included in the files (applicable to all except as noted):

- For each coverage option offered by a group health plan or issuer, the name and 14-digit Health Insurance Oversight System ("HIOS") identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or if no HIOS identifier is available, the Employer Identification Number ("EIN")
- A billing code, for prescription drugs must be a National Drug Code ("NDC"), and a plain language description for each billing code for each covered item or service under each coverage option offered by a plan or issuer
- In-network applicable amounts; out-of-network allowed amounts; or negotiated rates and historical net prices for prescription drugs (depending on the file)

All three files must include the provider's National Provider Identifier, tax identification number, and place of service code.

In-network rate file

- All applicable rates: negotiated rates, underlying fee schedule rates, or derived amounts.
- Rates shown as dollar amounts, associated with last date of the contract term or expiration date for each provider-specific applicable rate applicable to each covered item or service, and notes identifying where there is a reimbursement arrangement other than a standard fee-for-service model (such as capitation or a bundled payment arrangement).

Allowed amount file

- Includes all unique out-of-network allowed amounts and billed charges with respect to covered items or services furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file.

- Plans and insurers must omit allowed amount and billed charges data in relation to a particular provider and a particular item or service when compliance would require reporting in connection with fewer than 20 different claims for payment.

Prescription drug file

- Includes negotiated rates and historical net prices reflected as a dollar amount, with respect to each NDC that is furnished by an in-network provider.
- Rates are based on last date of the contract term for each provider-specific negotiated rate that applies to each NDC and associated with the 90-day time period that begins 180 days prior to the publication date of the file for each provider-specific historical net price that applies to each NDC. Must omit historical net pricing data in relation to a particular NDC and a particular provider when compliance would require reporting payment of historical net prices calculated using fewer than 20 different.

Notes