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INSIGHT

Legislative Update

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On September 25, 2021, the House Budget Committee advanced the Democrats' $3.5 trillion budget reconciliation package (Legislation) during a rare weekend session. The legislation includes most of President Biden's and Congressional Democrats' social and economic policy priorities, touching on various topics such as green energy tax credits, Medicare expansion, free community college, and universal preschool.

In addition, the legislation would undo many features of Republicans' *Tax Cuts and Jobs Act of 2017* (TCJA) and raise tax revenues by approximately $3 trillion over ten years.

Although the contents of the bill are still in flux, the following is a summary of the legislation as of the end of September 2021. In addition to a number of changes to tax rates (including individual, capital gains, and corporate), the legislation contains major health and retirement changes.

The major health provisions include:

- Expansion of Medicare to provide coverage for dental, hearing, and vision services;
- Allowing Medicare to negotiate prescription drug prices as seen in House Democrats' H.R. 3 legislation;
- Expansion of Medicaid in the 12 states that have not already done so;
- Expansion of the Affordable Care Act (ACA) premium tax credit subsidies;
- An expanded open enrollment period for certain low-income individuals;
- Establishment of a health insurance affordability fund to support either a state-level reinsurance program or to reduce out-of-pocket costs for eligible individuals;
- Expansion of the health coverage tax credit; and
- Broadening of the list of "non-ACA compliant health insurance coverage" to include association health plans and short-term limited duration insurance.

The retirement provisions include a number of long-standing Democratic priorities, among them:

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* A requirement for employers with more than five employees to provide access to a retirement plan that automatically enrolls employees by 2023 (governments and churches are exempt);
* Modification of the existing nonrefundable Saver's Credit to become a refundable tax credit that would be directly contributed to a tax-favored retirement account;
* Limitations on individuals with taxable income above $400,000 per year from contributing further to a traditional or Roth IRA if that individual has more than $10 million combined in aggregate IRA and defined contribution retirement accounts (along with new minimum required distribution rules for individuals who exceed these thresholds);
* Elimination of "back-door" Roth IRA conversions and in-plan Roth conversions of after-tax amounts; and
* Various restrictions on IRA investments and executive compensation.

The legislation also creates a new federal paid family and medical leave program, and extends many child and dependent tax credits.

Additional changes in the size and cost of the bill will likely be necessary for passage by the House and Senate. Further, at this point, it is unclear what health and retirement provisions will be palatable to the House and Senate for inclusion in any final version. Indeed, it appears that the entire reconciliation process could take a couple of months – and possibly until the end of the year – to play out as members of the Democratic caucus from both chambers and sides of the ideological spectrum try to reach consensus on the scope and contents of the legislation.

Although many of these items are more general in nature, they reflect the evolving views on the United States' retirement system and could, if more changes or lower limits come in the future, potentially impact governmental plans and their members.

New Cybersecurity Guidance

On April 14, 2021, the Department of Labor (DOL) announced new guidance on best practices for plan sponsors, fiduciaries, service providers, and participants around cybersecurity. The guidance has three parts: 1) Tips for Hiring a Service Provider; 2) Cybersecurity Program Best Practices; and 3) Online Security Tips.

This is the DOL's first cybersecurity guidance for retirement plans. Although not technically applicable to governmental plans, it provides tips that governmental plans may also consider.

The guidance states that ERISA requires that plan fiduciaries take precautions to mitigate these types of threats. However, at this time, it is not clear whether compliance with this cybersecurity guidance will provide a suitable defense to plan sponsors and fiduciaries if participants sue in response to a cyberattack.

The DOL's "Tips for Hiring a Service Provider" provides information to help plan sponsors of all sizes prudently to: 1) select service providers that follow strong cybersecurity practices; and 2) monitor such providers to ensure such practices are maintained. This guidance contains six tips, which generally require due diligence by plan sponsors, including reviewing a service provider's security standards, track record (including past breaches), and insurance policies for coverage of losses due to a breach. A plan sponsor should exercise caution for specific contract provisions, looking for inclusion of those permitting plan sponsor review of compliance audits, but avoiding those that limit the service provider's responsibility for cybersecurity breaches.

The guidance on "Cybersecurity Program Best Practices" seeks to assist service providers in establishing cybersecurity programs and plan fiduciaries in making prudent decisions related to hiring such service providers. The guidance provides a list of best practices, along with detailed action steps for each practice. The best practices

contemplate a robust program with ongoing training and assessments, in conjunction with clearly delineated roles and responsibilities.

Finally, the DOL's "Online Security Tips" offer security recommendations to plan participants and beneficiaries to protect them in their online activity, such as when checking their retirement account online. The content of this guidance contains familiar online safety tips and includes suggestions that accounts be set up and subject to sustained activity, strong passwords and multi-factor authentication be used, and individuals be wary of free Wi-Fi and phishing attacks.

Update on Actuarial Equivalence Lawsuits

In the July 2020 issue of *GRS Insight*, *Torres v. American Airlines* and other similar class action litigation addressing pension plan assumptions relating to actuarial equivalence were discussed. While many of the lawsuits in the initial round of filings have been resolved via either a motion to dismiss or settlement, at least seven suits remain active.

One such active case is scheduled for trial this fall, *Herndon v. Huntington Ingalls Industries, Inc.* In this case, the parties stipulated to class certification.

In *Torres*, after struggling to achieve class certification, the parties reached a settlement and the case was dismissed. Settlements in these cases have generally not been made public.

However, the settlement in *Cruz v. Raytheon Company* is public. The settlement in this case includes an agreed-upon payment to class members equal to 40% of the difference between the benefit value calculated by plaintiffs versus the benefit actually received (a settlement valued at $59 million), along with an agreement to change future assumptions.

Generally, new filings have dried up since December 2020. However, a new case, *Urlaub v. Citgo Petroleum Corp.*, was filed in early August 2021. The *Urlaub* case tracks prior cases in alleging the use of unreasonable actuarial equivalence factors—such as outdated mortality tables—when determining benefits.

The difference in this case is that Citgo had previously amended its plan to use more current factors – plaintiffs have latched onto this fact in claiming it shows Citgo knew its prior factors were illegal. This case brings to the forefront the challenge facing plan sponsors – *to amend or not to amend*?

Many plan sponsors have worried about this exact situation, where their actions would be used against them in a lawsuit and/or might flag the issue for their participants and lead to a lawsuit. On the other hand, Citgo's decision to amend would seem to have limited the potential class to participants who commenced their benefits prior to the amendment.

These lawsuits may have slowed, but the issue will have a long tail. As these current cases proceed, plan sponsors have the potential to gain real intelligence on the best path forward and should stay abreast of this topic when considering changes to future assumptions given the large amounts held in governmental plans.

COVID-19 Telemedicine Relief Ending

In light of the need to minimize the risk of exposure to and community spread of COVID-19, Congress and the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments) provided helpful relief allowing the expanded use of telemedicine. Although the COVID-19 pandemic remains ongoing, this relief will expire soon.

HSA Relief

Generally, an HSA-compatible high deductible health plan (HDHP) generally cannot cover telemedicine pre-deductible except for telemedicine related to preventive care, dental and vision. Additionally, telemedicine coverage provided outside of the HDHP on a pre-deductible basis (except for telemedicine related to preventive care, dental, and vision) will render an individual ineligible to contribute to an HSA. However, the CARES Act permits an HDHP to temporarily cover telemedicine and "other remote care services" pre-deductible.[1] An individual may also have access to coverage outside of the HDHP for telemedicine and other remote care services before satisfying the deductible without impacting the ability to contribute to an HSA.

This relief applies to telemedicine and other remote care services provided on or after January 1, 2020, with respect to plan years beginning on or before December 31, 2021.[2] Thus, for calendar year plans, this relief ends on December 31, 2021.

ACA Relief

On June 23, 2020, the Departments issued a frequently asked question (FAQ) permitting a large employer to offer a group health plan that solely provides benefits for telehealth and other remote care services to employees who are not eligible for any other group health plan offered by the employer.[3] Typically, such a stand-alone arrangement would violate the ACA market reform requirements, but the Departments provided relief from most of these requirements. However, the following requirements still apply:

- Prohibition of pre-existing condition exclusions or other discrimination based on health status;
- Prohibition of discrimination against individual participants and beneficiaries based on health status;
- Prohibition of rescissions; and
- Parity in mental health or substance use disorder benefits.

This relief applies for the duration of any plan year beginning before the end of the COVID-19 public health emergency. The current public health emergency declaration, which the HHS must renew every 90 days, expires on January 18, 2022.[4]

Surprise Billing: Part 1

On July 1, 2021, the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments) released an Interim Final Rule (IFR) with Comment Period on the "Requirements Related to Surprise Billing: Part 1." It is the first in a series of rules implementing the surprise billing and transparency requirements under the *Consolidated Appropriations Act of 2021* (CAA).

***Applicability*.** Surprise billing protections apply to group health plans and health insurance issuers offering group or individual health insurance coverage with respect to plan years beginning on or after January 1, 2022. It is also applicable to Federal Employee Health Benefit carriers, grandfathered health plans, and generally to indemnity-only plans.

Coverage of Emergency Services. If a plan or issuer covers emergency services, emergency services must be covered without regard to any term or condition of coverage, other than exclusion or coordination of benefits, an affiliation or waiting period, or

[1] *See Code § 223(c)(2)(E).*
[2] *See Notice 2020-29.*
[3] *See FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43, Q&A-14.*
[4] https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVDI-15Oct21.aspx

applicable cost sharing. Coverage must not require prior authorization and the plan or issuer must not impose cost sharing greater than if services had been provided by an in-network provider; must make the initial payment directly to the out-of-network provider within 30 days; and must count cost sharing toward in-network deductibles and out-of-pocket maximums. Denials for benefits for emergency services must be evaluated under the prudent layperson standard. Post-stabilization services, including observation and inpatient or outpatient services, that are related to the emergency visit will generally be treated as emergency services unless the patient receives notice from the provider and provides consent.

***Coverage of Nonemergency Services Provided by Nonparticipating Provider at Participating Facility*.** Generally, services in this category follow the same treatment as for coverage of emergency services, unless the provider satisfies notice and consent requirements. If the plan or issuer covers nonemergency items and services delivered by an out-of-network provider at an in-network facility, the plan or issuer must not impose cost sharing greater than if services had been provided by an in-network provider; must make the initial payment directly to the out-of-network provider within 30 days; and must count cost sharing toward in-network deductibles and out-of-pocket maximums. Protection from balance billing does not apply when the provider provides notice and receives consent from the patient.

***Provisions that Apply to Both Emergency Services and Nonemergency Services by Nonparticipating Providers in Participating Facilities*.**

- A "visit" is not limited to a single facility and includes imaging services, laboratory services, etc.
- The "recognized amount" is the amount distinct from the amount a plan or issuer pays the provider. Plans and issuers must base cost sharing paid by the participant on the recognized amount.
- There is a significant distinction between an adverse benefit determination (which can be disputed through plan's or issuer's claims and appeals process) and a denial of payment (which may be disputed through an open negotiation process or through the Independent Dispute Resolution (IDR) process).
- Cost sharing is generally calculated as if the total amount that would have been charged for services were equal to the recognized amount for such services. A recognized amount is determined by an applicable All-Payer Model Agreement, a state law, or the lesser of the Qualifying Payment Amount (QPA) or billed amount.
- An out-of-network rate is the total amount paid for the item or service by the plan or issuer, without including cost-sharing paid by the participant. When the out-of-network rate exceeds the amount upon which cost sharing is based, the plan or issuer must pay the difference. The total payment must equal an All-Payer Model Amount, amount specified by state law, amount agreed to by parties, or amount set by the IDR process.

***QPA Methodology*.** The QPA is the median of the contracted rates recognized by the plan or issuer for same or similar item or service in the same insurance market provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation.

***Disclosure Requirements and Model Notice*.** Certain QPA information must be disclosed to providers or facilities by plans and issuers, and providers or facilities can request more information. The Departments issued model disclosure notices that may be used by plans and issuers and providers or facilities to meet the requirement to disclose information on the balance billing protections. Until

future rulemaking happens, plans and issuers should exercise good-faith compliance with the disclosure provision on the balance billing protections.

***Enforcement*.** The Surprise Billing IFR temporarily extends the complaint process included in the CAA to all of the consumer protection and balance billing requirements in the IFR. The HHS issued a separate proposed rule amending its enforcement regulations.

***Sunsetting Provision*.** The CAA amended the Affordable Care Act's (ACA) emergency services rule, sunsetting the ACA emergency services rules which apply through the end of 2021.

FAQs about Affordable Care Act and Consolidated Appropriations Act

On August 20, 2021, the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments) released frequently asked questions (FAQs) regarding the implementation of the *Consolidated Appropriations Act of 2021* (CAA).

***Transparency in Coverage Machine Readable Files*.** The Transparency in Coverage final rule requires non-grandfathered group health plans and issuers to disclose on a public website information regarding in-network provider rates, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files. This requirement applies to plan years beginning on or after January 1, 2022.

In the FAQ guidance, the Departments will defer enforcement of the machine-readable file requirement for negotiated rates and historical net prices for covered prescription drugs until further notice-and-comment rulemaking, and defer enforcement of the machine-readable file requirement for the in-network provider rates, and out-of-network allowed amounts and billed charges for covered items and services until July 1, 2022.

***Price Comparison Tools*.** The Transparency in Coverage final rule requires plans and issuers to make price comparison information available to enrollees through an internet-based self-service tool and in paper form upon request. The tool must be available for plan years beginning on or after January 1, 2023 for 500 items and services identified by the Departments, and with respect to all covered items and services for plan years beginning on or after January 1, 2024. The CAA price comparison tool is applicable to plan years beginning on or after January 1, 2022.

Since the price comparison methods required by the CAA are largely duplicative of the internet-based self-service tool component of the Transparency in Coverage final rule, the Departments intend to propose rulemaking and seek public comment regarding whether compliance with the internet-based self-service tool requirements of the Transparency in Coverage final rule satisfy the analogous requirements set forth in the CAA.

***Transparency in Plan or Insurance Identification Cards*.** Plans and issuers must include any applicable out-of-pocket maximum limitations, and information on where consumers can seek assistance, on any physical or electronic plan or insurance ID card. These provisions apply to plan years beginning on or after January 1, 2022. The Departments will not be issuing regulations addressing this requirement prior to effective date, and plans and issuers are expected to implement this requirement using a good faith, reasonable interpretation of the law.

***Good Faith Estimate*.** Providers and facilities must inquire if a patient is enrolled in a health plan or insurance coverage, and provide notification of the good faith estimate of expected charges to plan or coverage. This is applicable to plan years beginning on or after January 1, 2022. The HHS will defer enforcement of the requirement to submit estimates to a plan or issuer until further rulemaking.

***Advanced Explanation of Benefits*.** Upon receiving a good faith estimate, plans and issuers must send a participant, beneficiary, or enrollee an Advanced Explanation of Benefits in clear and understandable language. The Departments will not be issuing regulations prior to the effective date and realize compliance is not possible by January 1, 2022. They will undertake notice-and-comment rulemaking in the future.

***Prohibition on Gag Clauses on Price and Quality Data*.** Plans and issuers are prohibited from entering into an agreement that would restrict providing provider-specific cost or quality of care information, electronically accessing de-identified claims and encounter data for beneficiaries, and sharing such information. The Departments state that the statute is self-implementing. Plans and issuers must submit an attestation of compliance with these requirements. These provisions were effective for contracts entered into after December 27, 2020. However, the Departments intend to issue implementation guidance to explain how plans and issuers should submit their attestations of compliance and anticipate beginning to collect attestations starting in 2022.

***Protecting Patients and Improving Accuracy of Provider Directory Information*.** Plans and issuers must establish a process to update and verify the accuracy of provider directory information and establish a protocol for responding to requests about a provider's network participation status. If a participant was provided inaccurate information about a provider, the plan or issuer cannot impose cost-sharing greater than what it would be for an in-network provider and must count cost-sharing toward any in-network deductible and maximum out-of-pocket limit. Plans and issuers must make certain disclosures regarding balance billing protections to participants that are similar to those applicable to providers and facilities. Until further rulemaking, plans and issuers are expected to implement these provisions using a good faith, reasonable interpretation of the statute.

***Continuity of Care*.** These protections ensure continuity of care when terminations of certain contractual relationships result in changes in provider or facility network status. This provision is applicable beginning January 1, 2022, and until rulemaking, plans, issuers, providers, and facilities are expected to implement requirements using a good faith, reasonable interpretation of the statute.

***Grandfathered Health Plans*.** Grandfathered health plans are subject to requirements under the CAA because the Act does not include an exception for grandfathered health plans.

***Reporting on Pharmacy Benefits and Drug Costs*.** Plans and issuers must submit relevant information to the Departments, including general plan information and information specific to prescription drugs and cost. The Departments will defer enforcement pending issuance of regulations or further guidance.

COVID-19 Vaccine Surcharges

Many employers are considering implementing incentive programs to encourage employees to get vaccinated, such as premium surcharges for employees who are not fully vaccinated. These premium surcharge programs implicate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Americans with Disabilities Act (ADA).

HIPAA

Generally, HIPAA prohibits a group health plan from setting contribution or premium rates for similarly situated individuals based on a health factor, which includes the receipt of health care. However, there is an exception for wellness programs, which are either participatory or health-contingent.

- In a participatory program, the ability to earn a reward does not depend on the individual satisfying a health standard related to a health

factor. An example of a participatory program is a diagnostic testing program that provides a reward for participation rather than achieving a certain outcome.

- A health-contingent program requires an individual to satisfy a standard related to a health factor to obtain a reward. There are two types of programs that are either activity-only or outcome-based.

On October 4, 2021, the Departments of Health and Human Services (HHS), Labor and the Treasury issued guidance that provides that a premium surcharge program is an activity-only program and thus must comply with the five criteria in the HIPAA wellness regulations. These criteria include (among other things) that:

- The program is reasonably designed to promote health or prevent disease;
- A reasonable alternative must be provided to obtain the reward for those for whom it is unreasonably difficult due to a medical condition or medically inadvisable to receive the COVID-19 vaccine; and
- The reward (when added to all other wellness incentives for health-contingent programs) must not exceed 30% of the total cost of coverage.

The new guidance provides that conditioning eligibility for benefits or coverage for otherwise covered items or services (including to treat COVID-19) for participants being vaccinated is not permissible under HIPAA, since it would be discrimination against these participants based on a health factor and the exception for wellness programs would not apply.

The new guidance also addresses how COVID-19 vaccine premium incentives impact affordability for purposes of the Affordable Care Act employer mandate. Similar to other non-tobacco premium incentives, vaccine incentives increase the cost of coverage for employer mandate purposes, even for those that are vaccinated.

ADA

If an employee gets the vaccine from a third party and not from the employer or its agent, the ADA does not apply. However, the employer must still provide a reasonable accommodation for employees that do not get the vaccine due to a disability or religious reason. If the employer or its agent gives the vaccine to an employee, the ADA wellness rules apply, which generally impose a 30% incentive limit.

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