Legal Update

March, 2021

Retirement Plans

THOMPSON HINE

What We Will Cover

- SECURE Act
- CARES Act
- Consolidated Appropriations Act (CAA)
- American Rescue Plan Act (ARPA)
- Other Recent Guidance
- Latest Litigation

SECURE Act

- Signed into law on December 20, 2019
- Formal plan amendments will be required no earlier than the end of 2022 for most changes but operational compliance is required sooner for certain provisions
- Some provisions have delayed effective dates for governmental plans and collective bargained groups/plans

SECURE Act

- Up to $5,000 penalty free withdrawals for birth or adoption - effective 1/1/20
- MRD changes including change in age from 70-1/2 to 72 for individuals who had not attained age 70-1/2 by 12/31/19
- Long-term, part-time employees (those who have completed 3 years of service and 500 hours per year) must be allowed to make 401(k) contributions effective for plan years beginning after 12/31/20. Only required to count years of service completed after the effective date.
    - **UPDATE:** IRS issued guidance containing details regarding these changes in September, 2020.

SECURE Act

- Changes designed to promote lifetime income options and disclosures.
    - **UPDATE**: Interim final rules regarding lifetime income disclosures issued on 9/18/20 with effective date of 9/18/21. We may see modifications under the final rule.
- For QACA safe harbor designs automatic increase cap is changed from 10% to 15% effective for plan years beginning after 12/31/19
- Non-elective safe harbor plans do not need to provide annual notice and design option can be implemented any time prior to 30th day before year end or, if willing to make 4% contribution, within the last 30 days of a plan year effective for plan years beginning after 12/31/19

CARES Act

- Signed into law on March 27, 2020
- Allowed 401(k) plans to permit special distributions and apply special rules to plan loans during 2020
- Eliminated MRDs for 2020
- Amendments required by end of 2022 plan year

Consolidated Appropriations Act

- Signed into law December 27, 2020
- Very few retirement-plan related provisions
  - Partial plan termination relief
  - Extension of special distribution and loan rules for non-COVID related qualified disasters

Consolidated Appropriations Act

- Partial Plan Termination Relief
  - Designed to address short-term workforce changes
  - Traditionally, whether a partial plan termination has occurred is based on the facts and circumstances, but generally is presumed to occur if the number of participants in a plan falls by 20% or more during the plan year. In that event, affected participants must be fully vested.
  - **Relief**: If the number of participants in the plan on March 31, 2021 is at least 80% of the number of participants in the plan on March 13, 2020, no plan termination will have occurred in either 2020 or 2021

Consolidated Appropriations Act

- Disaster Relief
  - Provides **optional** CARES Act-like relief to those impacted by a federally-declared disaster that occurred between 12/28/19 and 12/27/20 (and declared between 1/1/20 and 2/25/21)
  - Excludes the COVID-19 pandemic
  - Available to those individuals who suffered an economic loss as a result of the disaster and whose principal abode during the incident period was in a qualified disaster area

American Rescue Plan Act

- Signed into law on March 11, 2021
- Bulk of changes impacting benefits apply to health plans
- However the act does contain favorable pension funding relief provisions

Other Updates - Final Rule on Financial Factors in Selecting Plan Investments

- Effective January 12, 2021
- The selection of investment options to serve non-pecuniary interests raises fiduciary concerns under ERISA
- The Rule sought to resolve the uncertainty created by seemingly conflicting prior DOL sub-regulatory guidance regarding what role non-pecuniary factors may serve in the selection of plan investments

Final Rule on Financial Factors in Selecting Plan Investments

- An ERISA fiduciary must evaluate investments solely on pecuniary factors and not subordinate plan participants' and beneficiaries' pecuniary interests to achieve non-pecuniary goals
- A pecuniary factor is one "that a fiduciary prudently determines is expected to have a material effect on the risk and/or return of an investment based on appropriate investment horizons consistent with the plan's investment objectives and the funding policy established pursuant to section 402(b)(1) of ERISA"

Final Rule on Financial Factors in Selecting Plan Investments

- **Narrow Exception**: If a plan fiduciary is unable to distinguish between two investments based solely on pecuniary factors, the fiduciary may use non-pecuniary factors to make an investment decision provided the fiduciary documents (i) why pecuniary factors alone were insufficient, (ii) how the selected investment varies from alternatives, and (iii) how the non-pecuniary factors used are consistent with the participants' and beneficiaries' interests

Final Rule on Financial Factors in Selecting Plan Investments

- **A word of caution in the rule preamble**: The DOL "cautions fiduciaries against too hastily concluding that ESG*-themed funds may be selected based on pecuniary factors or are not distinguishable based on pecuniary factors"
- **But not the final word:** On March 10, 2021 the DOL issued a non-enforcement policy, once again creating uncertainty over whether such funds/factors can be considered in selecting investments for retirements plans

*ESG = Environmental, social, governance

Other Updates - Missing Participants

- In January 2021, the DOL issued non-binding guidance focused on the issue of missing participants
- The guidance identifies red flags that indicate a plan has a problem, including (1) more than a small number of missing or nonresponsive participants; (2) missing, inaccurate, or incomplete contact information; and (3) absence of sound policies and procedures for handling returned mail and/or uncashed

Missing Participants

- The guidance identifies steps the DOL believes fiduciaries should be taking to locate missing participants including (1) maintaining accurate census information for the plan's participants; (2) implementing effective communication strategies; (3) conducting robust missing participant searches; (4) documenting procedures and actions
- While consistent with past guidance, the best practices guidance provided a clearer statement of the DOL's expectations in this area

Other Updates - Cycle 3 Plan Restatements

- IRS opinion letters for pre-approved DC plans were issued last summer
- Adopting employers have a 2-year period starting August 1, 2020 and ending July 31, 2022 to restate their plans and seek a determination letter in appropriate circumstances
- Most recordkeepers have taken a staggered approach for restatements

REMINDER: Plan amendments for changes to hardship distribution rules required by December 31, 2021

Other Updates Expected/Needed Soon

- Additional SECURE Act guidance including more guidance regarding MRDs long-term, part-time employees and lifetime income disclosures
- Cybersecurity obligations and best practices
- Matching contributions related to student loan repayments
- EPCRS update

Latest Litigation - 401(k) Plan Fee/Fund Litigation

- There continues to be a significant number of high dollar settlements
- New cases continue to be filed against sponsors of 401(k), 403(b) and pension plans
- Establishment of a robust fiduciary oversight structure and process is key to avoiding and/or defeating claims

401(k) Plan Fee/Fund Litigation

Requires implementation and maintenance of best practices:

- Establish a committee with a charter and quarterly meetings
- Regular review of fund performance and fees in accordance with investment policy statement and against benchmarks
- Issue RFP for plan paid services every 3 – 4 years
- Engage experts including independent investment consultant and legal
- Monitor high profile regulatory actions against plan service providers
- Ensure plan data is secure and not being used by recordkeeper to sell non-plan related services
- Documentation of all committee reviews and decisions

Latest Litigation - Cybersecurity – Abbott Labs

- A hacker impersonated a participant online at the plan's website and on multiple calls over multiple days to the call center, resulting in $245,000 being transferred to the hacker
- Abbott was dismissed from the lawsuit but the Court denied the motion to dismiss the recordkeeper. The Court did not make a determination as to whether ERISA's duty of prudence extends to the "safeguarding of data and prevention of scams"

Cybersecurity – American Trust

- Plaintiffs are the plan sponsor (Mandli Company) and a participant (Mr. Mandli, founder of company). Defendant is American Trust, as “discretionary trustee”
- Allegation is that American Trust made an unauthorized distribution in the total amount of $124,105 from Mr. Mandli’s account in response to a request for a distribution from an unknown third party
  - AT forwarded distribution paperwork to a third party at an email address/physical address that was not in the plan’s database as being Mandli’s address
  - Distribution was made by ACH or wire to an account not belonging to Mandli
  - AT did not mail or email acknowledgement or receipt to Mandli’s known addresses
  - In addition, plaintiffs alleged that American Trust “concealed” the true facts around the unauthorized distribution when it was discovered

Laura A. Ryan
Thompson Hine LLP
513.352.6727
Laura.Ryan@ThompsonHine.com

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Legislative Update
Health and Welfare

March 24, 2021

Kim Wilcoxon

THOMPSON HINE

Today's Presentation

- CAA FSA Relief
- Outbreak period deadline extensions
- COBRA subsidies
- CAA mental health parity analyses
- Surprise billing
- Transparency and reporting

FSA Relief - Overview

- The Consolidated Appropriations Act and IRS Notice 2021-15 provide four types of relief
  - Unlimited carryover or extended grace period
  - Mid-year election changes without a life event
  - Health care FSA spend-down provision
  - Reimbursement of care for a 13-year-old child
- All types of relief are permissive – none are mandatory
- Depending on the relief adopted, a plan amendment may be required by December 31, 2021 or December 31, 2022.

FSA Relief – Carryover or Grace Period

- A plan can adopt either the carryover or the grace period regardless of how the plan was designed prior to the CAA
- Both options prevent forfeiture of unused funds in the 2020 and/or 2021 plan years
- The carryover is administratively easier and prevents forfeitures that might otherwise occur under the grace period
  - The grace period, when adopted with a spend-down provision, extends the time during which a terminated participant may incur reimbursable expenses
- Employees entitled to the carryover or extended grace period will be ineligible to contribute to an HSA for the following year unless the funds are HSA-compatible
- Additional amounts available do not impact:
  - Maximum contribution amounts
  - The health care FSA's status as an excepted benefit
  - Application of COBRA
  - Dependent care FSA amounts reported on Form W-2
    - It is currently unclear whether excess dependent care FSA reimbursements would be taxable, but the American Rescue Plan Act raises the income exclusion limit to $10,500 for 2021

FSA Relief – Carryover or Grace Period

- Example:
  - Assume Employee has $2,000 in an FSA as of 12/31/20
  - Employee contributes $2,000 for 2021 and receives reimbursement of $1,000 in 2021
  - Employee contributes $2,000 for 2022

Carryover	Grace Period
• $2,000 carries over from 2020 to 2021 • $4,000 available for use in 2021	• $2,000 from 2020 may be used in 2021 • $4,000 available for use in 2021
• $3,000 ($1,000 from 2020 and $2,000 from 2021) carries over from 2021 to 2022 • $5,000 available for use in 2022	• $1,000 from 2020 is forfeited • $2,000 from 2021 may be used in 2022 • $4,000 available for use in 2022

FSA Relief – Carryover or Grace Period

- Options to consider

Adopt Carryover?	Adopt Extended Grace Period?
For 2020 and/or 2021?	For 2020 and/or 2021?
Healthcare FSA and/or dependent care FSA?	Healthcare FSA and/or dependent care FSA?
Allow the full unused amount to carry over or limit carryover amount?	Extend grace period to December 31 or an earlier date?
Require a participant to have elected contributions to be eligible for the carryover?	N/A
Allow participants to opt out?	Allow participants to opt out?
Automatically convert carryover funds to limited purpose or allow employee choice?	Automatically convert grace period funds to limited purpose or allow employee choice?

FSA Relief – Mid-Year Election Changes

- The plan may allow employees to make any prospective changes to medical, dental, and/or vision coverage during the plan year ending in 2021
  - An employee may not drop medical coverage unless the employee attests in writing that he/she is enrolled or immediately will enroll in other comprehensive health coverage
- The plan may allow employees to make any prospective changes to FSA elections in the plan year ending in 2021
  - The plan may apply limits, such as:
    - Changes permitted only during a limited window
    - Employees allowed to drop dependents or coverage but not to add
- Similar relief was provided in 2020

FSA Relief – Mid-Year Election Changes

- Options to consider
  - Allow changes to medical, dental, vision, healthcare FSA and/or dependent care FSA elections?
  - Allow changes from a general purpose FSA to a limited purpose FSA?
  - Limit changes to a window or certain number of changes?
  - Limit to certain types of changes (e.g., decrease but not increase)?
  - If an employee elects to begin FSA contributions, allow for reimbursement of 2021 expenses incurred before contributions begin?
  - If an employee elects to stop FSA contributions, permit reimbursement of 2021 expenses incurred after contributions stop?

FSA Relief – Spend-Down Provision

- The plan may be amended to permit reimbursement for otherwise-eligible expenses incurred during the plan year and associated grace period following termination of participation in the health care FSA
  - Applies for plan years ending in 2020 and/or 2021
  - May limit reimbursement amount to the amount of unused contributions (the full year's election amount need not remain available)
- Interaction with carryover/grace period relief
  - If the unlimited carryover is adopted, a terminated participant will have only until the end of the plan year to spend down the account
  - If the extended grace period is adopted, a terminated participant will have until the end of the following plan year to spend down the account

FSA Relief – Spend-Down Provision

- Options to consider
  - Add a spend down provision to the health care FSA?
  - Apply for 2020 and/or 2021?
  - Limit the spend-down to the amount of contributions made to date minus the amount of reimbursements made to date?

FSA Relief – Age 13 Expenses

- The plan may be amended to permit 2020* contributions to be used for care of a child who turns 13 in 2020 or 2021
  - If the child turns 13 in 2020
    - Expenses for care of the 13-year-old child in 2020 are reimbursable
    - Expenses for care of the 13-year-old child in 2021 are reimbursable from any dollars left over from 2020
  - If the child turns 13 in 2021
    - Expenses for care of the 13-year-old child in 2021 are reimbursable from any dollars left over from 2020

*This relief applies to the last plan year with respect to which the end of the regular enrollment period was on or before January 31, 2020 (2020 for calendar year plans)

FSA Relief – Age 13 Expenses

- Options to consider:
  - Adopt age 13 relief for 2020 and/or 2021?

Outbreak Period Deadline Extensions

The Outbreak Period is disregarded for purposes of determining the following deadlines:

Medical						Medical	Medical
HIPAA special enrollment	COBRA election	COBRA payment	COBRA qualified beneficiaries to provide notice of a qualifying event or a disability	Filing a claim	Requesting an appeal	Requesting an external review	Perfecting an external review
All Group Health Plans				All ERISA Plans			

Outbreak Period Deadline Extensions

- Outbreak period
  - Begins March 1, 2020
  - Ends 60 days after the end of the national emergency
    - End of the national emergency will be announced
    - Emergency may end at different times in different parts of the country
- However, the DOL/IRS do not have authority to require a plan to disregard a period of more than one year
  - Impact of this one-year limitation was not clear when guidance was issued last year
  - Clarifying guidance was issued on February 26, 2021

Outbreak Period Deadline Extensions

- Assume the national emergency ends January 30, 2022 and the Outbreak Period ends March 31, 2022
- The Outbreak Period (but no more than one year) must be disregarded in determining a COBRA election deadline
  - Example 1:
    - If Amy's 60-day COBRA election period began February 20, 2020, her election deadline normally would fall on April 19, 2020
    - The period of March 1, 2020 through February 28, 2021 is disregarded
    - Amy's COBRA election deadline is April 19, 2021
  - Example 2:
    - If Amy's 60-day COBRA election period began February 20, 2022, her election deadline normally would fall on April 20, 2022
    - The period of February 20, 2022 through March 31, 2020 is disregarded
    - Amy's COBRA election deadline is May 30, 2022

Outbreak Period Deadline Extensions

- Issues to consider
  - To what extent should individuals be notified of the one-year extension limitation?
    - SMM for benefits-eligible employees
    - Notice to persons whose COBRA election or payment deadline fell within the outbreak period
    - Updated COBRA election notice
    - Targeted notice to persons whose deadlines now fall on or soon after March 1, 2021
    - Any other?
  - Should the plan apply the one-year limitation or be more generous?
    - Further extension may be appropriate for deadlines now falling on or soon after March 1, 2021
    - Further extension may be helpful for administrative ease
    - Administration should be coordinated with benefit enrollment vendor, COBRA administrator, and claims administrators
    - May need approval from insurer or stop loss carrier for voluntary extensions
  - Coordinate with insurers and administrators

COBRA Subsidies

Note: Guidance is expected and may impact this summary

- The American Rescue Plan Act provides a full COBRA* subsidy from April 1, 2021 through September 30, 2021 for subsidy-eligible individuals
  - Must have lost medical, dental, and/or vision coverage due to involuntary termination or reduction in hours
  - Must not be eligible for other group health plan coverage or Medicare
  - Includes persons on COBRA coverage during the subsidy period or who would have been on COBRA coverage during the subsidy period if COBRA had been elected or had not been dropped
    - Such individuals have the ability to enroll for coverage prospectively beginning April 1, 2021

*Applies to coverage provided under the federal COBRA law as well as comparable state continuation coverage

COBRA Subsidies

Note: Guidance is expected and may impact this summary

- Example 1:
  - Amy was involuntarily terminated October 15, 2019.
  - If she had elected COBRA coverage, it would have been effective from November 1, 2019 through April 30, 2021.
  - So long as Amy is not eligible for other group health plan coverage or Medicare on April 1, 2021, she may enroll in COBRA coverage for free for the month of April 2021
- Example 2:
  - Amy was involuntarily terminated October 15, 2020.
  - If she had elected COBRA coverage, it would have been effective from November 1, 2020 through April 30, 2022.
  - Because of the Outbreak Period, Amy is still in her COBRA election period
  - It is unclear whether Amy may choose:
    - To elect COBRA effective November 1, 2020 (retroactive premiums are required for coverage prior to April 2021)
    - If she is not eligible for other group health plan coverage or Medicare on April 1, 2021, to elect COBRA effective beginning April 1, 2021

COBRA Subsidies

Note: Guidance is expected and may impact this summary

- Required notices
  - Notice to subsidy-eligible individuals who became entitled to elect COBRA prior to April 1, 2021
    - Notice must be provided by May 31, 2021
  - Modified COBRA election notice for qualified beneficiaries who become entitled to elect COBRA during the subsidy period
  - Notice to persons whose subsidy will expire for reasons other than eligibility for other group health plan coverage or Medicare
    - Must be provided at least 15 days but no more than 45 days prior to the end of the subsidy
- The DOL is required to provide model notices

COBRA Subsidies

Note: Guidance is expected and may impact this summary

- Mechanics
  - Assistance eligible individuals elect COBRA, but pay no premiums for the months of April 2021 through September 2021
  - For self-funded plans, the employer takes a payroll tax credit for the amount of the COBRA premium that assistance eligible individuals otherwise would pay
    - If COBRA coverage would be subsidized by the company, the company likely will be able to take a payroll tax credit only for the unsubsidized portion
  - The process may be different for fully-insured benefits

COBRA Subsidies

Note: Guidance is expected and may impact this summary

- Optional election change
  - An employer may - but is not required to - allow assistance eligible individuals to switch into a lower-premium plan option
  - The enrollment change must be requested within 90 days after receipt of notice

COBRA Subsidies

Note: Guidance is expected and may impact this summary

- Issues to consider
  - Identify former employees who lost health coverage due to an involuntary termination of employment or reduction in hours
    - May go as far back as October 2019 (first month of COBRA would have been November 2019)
      - Guidance is needed to confirm whether earlier terminations should be considered for those spouses/children with second qualifying event extensions
    - Guidance should confirm the definition of “involuntary termination” – consider whether termination reason codes capture all involuntary terminations
  - Consider whether to allow assistance eligible individuals to switch into a lower-premium plan option
  - Consider whether to provide initial communication or wait for DOL model notices
  - Coordinate with COBRA administrator
  - Consider whether to revise severance plans or practices that provide a voluntary subsidy
  - Consider potential impact on claims experience

Mental Health Parity

- Group health plans must perform and document comparative analyses of the design and application of nonquantitative treatment limitations (NQTLs)
- Beginning February 10, 2021, group health plans must provide to the DOL upon request:
  - The written analyses
  - The specific plan or coverage terms regarding the NQTLs and a description of all MH/SUD and med/surg benefits to which each such term applies in each respective benefits classification
  - The factors used to determine that the NQTLs will apply to MH/SUD and med/surg benefits
  - The evidentiary standards used for such factors
  - Specific findings and conclusions reached by the plan which indicate that the plan is or is not in compliance

Mental Health Parity

The mental health parity regulations contain the following requirement for NQTL compliance:

A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

Mental Health Parity

- Issues to consider
  - Ask the TPA/insurer whether they have prepared these analyses for the NQTLs under their standard plan design. If so:
    - Request a copy
    - Identify the NQTLs applicable under the plan and determine whether the TPA/insurer's analysis addresses each NQTL
    - Confirm whether each NQTL is part of the TPA's/insurer's standard plan design or whether it was requested by the employer
  - If the TPA/insurer will not provide assistance, consider other compliance options

Surprise Billing

Effective for plan years beginning on or after January 1, 2022, new requirements apply for emergency out-of-network services, non-emergency out-of-network services provided at an in-network hospital, and out-of-network air ambulance services

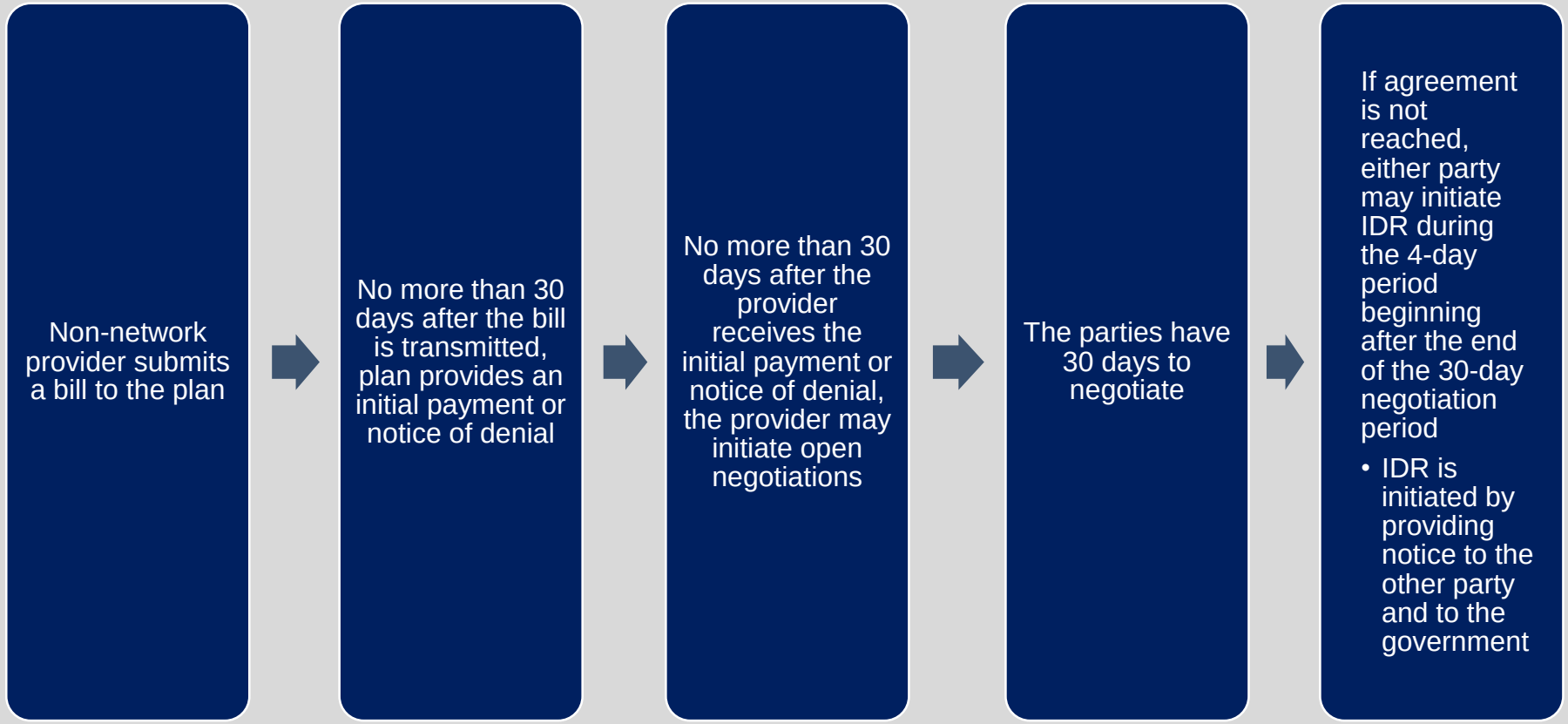
Under current law	Under the No Surprises Act Effective for plan years beginning on or after January 1, 2022
For emergency services: A participant's cost-sharing must not be more than in-network cost-sharing for the same expenses *For non-emergency services*: A participant's cost-sharing is set by the plan, and may be higher than the cost-sharing required for network services	*For air ambulance services*: Cost-sharing must be the same as in-network cost-sharing for the same expenses -and- The cost-sharing amount must be calculated based on the rates that would apply if services were provided by a participating provider *For all other affected services*: A participant's cost-sharing must not be more than in-network cost-sharing for the same emergency expenses -and- The cost-sharing amount must be calculated based on the "recognized amount" (generally, the median of contracted rates)

Surprise Billing

Effective for plan years beginning on or after January 1, 2022, new requirements apply for emergency out-of-network services, non-emergency out-of-network services provided at an in-network hospital, and out-of-network air ambulance services

Under current law	Under the No Surprises Act Effective for plan years beginning on or after January 1, 2022
For emergency services: The health plan must pay the non-network provider no less than the greatest of the following three amounts (not including participant cost-sharing): • the median of the amount negotiated with in-network providers • the amount the plan generally pays for out-of-network services • the amount that would be paid under Medicare Parts A and B *For non-emergency services*: No minimum payment is required by law.	*For emergency services*: The health plan must pay the non-network provider no less than the "out-of-network rate," which is: • An amount set by applicable state law or state All-Payer Model Agreement • If no state law or All-Payer Model Agreement applies, an amount agreed to by the plan and provider • If no agreement is reached, the amount determined through binding arbitration
The participant can be balance billed for the difference between the provider's cost and the health plan's payment	The participant cannot be balance billed for the difference between the provider's cost and the health plan's payment

Surprise Billing



Surprise Billing

Each party submits:
- An offer for a payment amount
- Information to support the offer
- Information requested by the IDR entity

The IDR entity considers:
- Each offer and the information submitted
- "Qualifying payment amounts" (generally, the median contracted rate) for comparable items/services furnished in the same geographic region
- Certain other circumstances

The IDR entity may not consider:
- UCR
- The amount the provider would have billed if this Act did not apply
- Medicare payment rates

The IDR entity selects one of the offers
- The party whose offer was not selected must pay the fees charged by the IDR entity
- Each party must pay a fee to the government

Payment must be made within 30 days of the IDR entity's determination

Information about the IDR process (including the identity of the parties) will be published on the HHS website

Surprise Billing

- Issues to consider
  - A plan amendment/SPD update likely will be required for the 2022 plan year to reflect the new cost-sharing requirements and provisions applicable to non-network provider payments
  - Consider whether to delegate responsibility for provider negotiations to the TPA
  - The administrative services agreement with the TPA should be amended
    - To require the TPA to perform the surprise billing services as required by law
    - (As necessary) To provide sufficient indemnification protections in the event the TPA does not comply with the applicable legal requirements

Transparency and Reporting

- The CAA and recent regulations impose a significant number of new reporting and disclosure requirements
  - Some requirements apply only once, whereas others require repeated disclosures
  - The effective dates vary
  - Most disclosures required by a group health plan likely will be provided by the TPA/insurer

Transparency and Reporting

Not later than December 27, 2021 and by June 1 of each year thereafter, group health plans must submit the following pharmacy benefit and drug cost information to the agencies:

- The beginning and end dates of the plan year
- The number of enrollees
- Each state in which the plan or coverage is offered
- The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan, and the total number of paid claims for each such drug
- The 50 most costly prescription drugs with respect to the plan by total annual spending, and the annual amount spent by the plan for each such drug
- The 50 prescription drugs with the greatest increase in plan expenditures over the previous plan year and, for each such drug, the change in amounts expended by the plan in each such plan year
- Total spending on health care services by such plan, broken down by certain types of costs
- The average monthly premium paid by employers
- The average monthly premium paid by enrollees
- Any impact on premiums by rebates, fees, and any other compensation paid by drug manufacturers
- A reduction in premiums and out-of-pocket costs associated with compensation paid by drug manufacturers

Transparency and Reporting

- For plan years beginning on and after January 1, 2022, group health plans must provide information about the surprise billing requirements
  - Publicly available, posted on a public website
  - Included on each EOB subject to the surprise billing requirements

Transparency and Reporting

- Group health plans must report to the government
  - Within 90 days after the last day of the first calendar year that begins on or after the date final regulations are promulgated
    - Claims data for air ambulance services, based on
      - Whether services were emergency or non-emergency
      - The type of program of which the provider is a part
      - Whether the transport originated in a rural or urban area
      - Type of aircraft
      - Whether the provider has a contract with the plan
      - Other information specified by the Secretary
  - Within 90 days after the end of the calendar year immediately after the year described above
    - The information described above for the reporting year

Transparency and Reporting

- For plan years beginning on or after January 1, 2022, group health plans must include the following information on any physical or electronic plan or insurance ID card:
  - Any applicable deductible
  - Any applicable out-of-pocket maximum
  - A telephone number and website where the participant can seek consumer assistance information such as locating participating hospitals and urgent care facilities

Transparency and Reporting

- Beginning January 1, 2022*, if a patient schedules a service at least 3 business days in advance:
  - The provider must:
    - Ask whether the patient is enrolled in a group health plan and, if so, if the patient will be billing to the health plan
    - Provide a good faith estimate of the expected charges to the health plan
  - When a group health plan receives that notice, the group health plan must provide a notice to the participant

*These requirements apply to providers beginning January 1, 2022 and to group health plans for plan years beginning on or after January 1, 2022

Transparency and Reporting

Content:

- Whether the provider or facility is in the network
  - If so, the contracted rate for the requested service
  - If not, a description of how the patient may obtain information on participating providers and facilities
- The good faith cost estimate given by the provider
- A good faith estimate of the amount to be paid by the plan
- A good faith estimate of the required cost-sharing
- A good faith estimate of the amount that the patient has incurred toward the deductible and out-of-pocket maximum
- A disclaimer that the service is subject to a medical management technique (if applicable)
- A disclaimer that the information is only an estimate and is subject to change

Timing:

- If the service is scheduled at least 10 business days in advance, within 3 business days after the plan receives notification
- Otherwise, within 1 business day
- If the patient requests – within 1 business day
- Agency guidance may allow for a delay for certain services

Transparency and Reporting

- For plan years beginning on or after January 1, 2022, if a plan and provider terminate their contractual relationship while a covered person is a continuing care patient
  - The plan must notify the covered person about the termination and the covered person's right to elect continued transitional care
  - If elected by the covered person, the plan must continue to treat the services as in-network services for 90 days (or, if earlier, until the continuing care ends)
  - The provider must continue to accept negotiated payment.
- Requirements do not apply if the relationship is terminated due to failure to meet applicable quality standards or fraud

Transparency and Reporting

Continuing care patient

- Undergoing a course of treatment for a serious and complex condition
- Undergoing a course of institutional or inpatient care
- Scheduled to undergo nonelective surgery, including postoperative care
- Is pregnant and undergoing a course of treatment for pregnancy
- Is or was determined to be terminally ill and is receiving treatment for that condition

Transparency and Reporting

- For plan years beginning on and after January 1, 2022, group health plans must
  - Establish a process to verify provider directory information at least every 90 days and remove unverified providers
  - Establish a protocol for responding to participant requests regarding whether a provider is a covered provider
  - Host a database of participating providers on a public website
  - Include a disclaimer on paper copies of provider directories
  - Apply in-network cost sharing, deductibles, and out-of-pocket maximums if the participant used the database/directory/response protocol and was told that the provider was in the network

Transparency and Reporting

- For plan years beginning on or after January 1, 2022, group health plans must offer price comparison guidance
  - By telephone
  - Through a tool available on an internet site
- Enrolled persons must be able to compare the cost-sharing that would be required for a specific item or service with respect to participating providers in the same geographic region

Transparency and Reporting

- For plan years beginning on and after January 1, 2022, group health plans must make publicly available three machine readable files

In-network Rate File	*Allowed Amount File*	*Prescription Drug File*
In-network negotiated rates for all covered items and services between the plan and providers	Out-of-network allowed charges and billed amounts during a recent 90-day period	In-network prescription drug negotiated rates and historical net prices for all covered prescription drugs by plan at the pharmacy location level

Transparency and Reporting

- For plan years beginning on and after January 1, 2023, group health plans must provide a self-service tool to allow participants to obtain advance estimates of expected costs for at least 500 covered items and services
- For plan years beginning on and after January 1, 2024, the self-service tool must include all covered items and services

Transparency and Reporting

- Effective immediately, group health plans may not enter into agreements that would directly or indirectly restrict the plan from:
  - Providing provider-specific cost or quality of care data
  - Electronically accessing de-identified claims
  - Electronically accessing claims data for each enrollee
  - Sharing such information with a business associate
- Applies to agreements with:
  - Health care providers, networks or associations of providers
  - Third-party administrators
  - Other service providers offering a network of providers
- Plans must annually provide the government with an attestation that the plan is in compliance

Transparency and Reporting

- Reporting to state all-payer claims databases will be voluntary

Issues to Consider

- Ensure that service provider agreements are amended as necessary to reflect the vendor's performance of the new services
- Confirm that service provider agreements do not contain gag clauses or other clauses that would prohibit disclosure of the required information
- Confirm that service provider agreements contain sufficient indemnification provisions
- Confirm that service provider agreements contain sufficient data security provisions

Kim Wilcoxon
Thompson Hine LLP
513.352.6524
Kim.Wilcoxon@ThompsonHine.com

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