NCCMP Annual Conference

Contemporary Compliance Issues

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September 27, 2021

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Agenda

Retirement Plan Issues

COVID-19

Health & Welfare Plan Issues

Discussion

Retirement Plan Issues

Cybersecurity

- In April 2021, DOL published guidance on cybersecurity practices
- Cybersecurity Program Best Practices — Plan sponsors should share these best practices for reducing cybersecurity risks with recordkeepers and other service providers that have access to plan-related data and technology
- Tips for Hiring a Service Provider with Strong Cybersecurity Practices — These are action items for plan sponsors and fiduciaries to help them evaluate the strength of a service provider's cybersecurity program.
- Online Security Tips — These are steps individuals can take to help protect their plan benefits and personal information from cybercriminals.

HIPAA Security Law: New Incentive to Adopt Recognized Security Practices

- New federal law enacted January 5, 2021 (Public Law 116-321)
- Applies to covered entities (e.g., health plans and health care providers) and business associates subject to HIPAA security rule
- HHS is now required to consider entity's adoption of "recognized security practices" in its enforcement activities under the HIPAA security rule
- Recognized security practices include standards, guidelines and best practices developed by the National Institute of Standards and Technology (NIST)
- Adoption of such standards can mitigate fines or result in early, favorable termination of HHS audit

Revisions to Retirement Plan Corrections Program

- The latest update to the IRS Employee Plans Compliance Resolution System (EPCRS), which was issued on July 16, 2022 as Rev. Proc. 2021-30, makes these changes:
  - Expands guidance on recouping overpayments
  - Replaces the anonymous submission procedure under VCP with a no-cost anonymous pre-submission conference procedure
  - Extends the SCP correction period for significant failures from two years to three years
  - Eliminates the requirement that a corrective amendment of a plan operational failure has to apply to all participants
  - Extends until 2023 the temporary automatic enrollment 401(k) special correction
  - Increases the amount for which no correction is needed (from $100 to $250)

Expanded Guidance on Recouping Overpayments

- The revised EPCRS allows plans to offer the participant or beneficiary the ability to repay an overpayment in a lump or installment payments
- In addition, effective July 16, 2021, EPCRS creates two additional methods for DB plans:
  - Funding exception correction (FEC) method
  - Contribution credit correction (CCC) method

Missing Participants Update

- DOL remains focused on whether plan sponsors are taking sufficient steps to identify, locate, and apprise deferred vested participants who have reached NRA of their right to commence benefits.
- Investigations focused on this issue have generally resulted in plans having to account for the above-referenced participants for whom the plan does not have accurate contact information and engage in prudent efforts to find such individuals. The length of any such investigation often depends on the plan's progress and success in doing so.
- DOL released guidance for plan sponsors on January 12, 2021. The guidance reflects DOL's focus on the accuracy of participant census records, procedures for finding missing individuals, communication practices for participants approaching NRA, and the plan's protocols for addressing uncashed pension checks.

COVID-19

Relief for Losses Related to COVID-19 for Retirement Plans

- In addition to the historic relief made available by the American Rescue Plan Act of 2021 for financially troubled multiemployer pension plans, the Act permits pension plans to amortize its investment losses occurring in the two plan years ending after February 29, 2020 over thirty years.
- Plans may also extend the amortization period for “other” losses due to COVID-19, such as experiences losses resulting from reductions in hours and corresponding contribution payments.
- Losses may also be smoothed over 10 years.
- Electing plans must demonstrate solvency and will be subject to restrictions on benefit increases.

Families First and CARES Acts
COVID-19 Testing and Visits

- Effective March 18, 2020 through the end of the Public Health Emergency (Currently July 20, 2021) group health plans and insurers must cover without cost sharing:
  - COVID-19 diagnostic and serologic tests
  - Test administration
  - Visit (office, urgent, ER, telehealth) and items/services related to ordering of or administration of test
- How can plans determine whether tests are medically necessary?

CARES Act
Interim Final Rule released 10/29/20

- Non-grandfathered group health plans must cover COVID-19 vaccine(s) without cost sharing within 15 business days of recommendation from ACIP/CDC
- Vaccines and other services must be covered in- and out-of-network during Public Health Emergency
- Plan must reimburse out-of-network providers a “reasonable amount” based on market rates
  - Medicare rate would be reasonable

Plan Coverage of PPE, Home Tests, Telemedicine

- IRS Announcement 2021-7 clarifies that health plan sponsors can choose to cover COVID-19-related PPE such as masks, hand sanitizer and sanitizing wipes for the primary purpose of preventing the spread of COVID-19
- IRS announced COVID-19 home tests are qualified medical expenses
- Special rules for telemedicine coverage

COVID-19 Vaccine and the EEOC

- Existing guidance addresses obligation to provide accommodations to individuals with a medical or religious reason they cannot take the vaccine
  - https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws
- Presidential Directive to mandate vaccination
- What are multiemployer trustees considering?
  - Are plans creating wellness incentives for the vaccinated?
  - Vaccination fairs (will the carriers support and pay for?)
  - Penalties for the unvaccinated?

Health Plan Issues

Health Plan Audits

Both DOL and HHS continue active programs to audit group health plans.

- Multiemployer and large self-funded and fully-insured plans are targets of DOL audits.
- Nonfederal governmental plans are the focus of HHS audits.
- Mental Health Parity Compliance under increased scrutiny

Focus includes:

- Mental Health Parity and Addiction Equity Act (MHPAEA)
- Grandfathered status
- Affordable Care Act (ACA) group market requirements
- HIPAA/ACA Wellness Program Rules

COVID-19 Oversight

- DOL added a new component to all civil health investigations.
- Investigations have begun to request specific claims data to verify compliance with FFCRA and CARES Act provisions.
- For example, a Federal review will look at claims to ensure COVID-19 testing was covered without cost-sharing by the patient.

Pre-CAA DOL Parity Oversight

- Targeted parity enforcement announced in DOL 2018 and 2020 Reports to Congress
- 127 FY 2020 investigations involved MHPAEA; EBSA obtained corrections impacting 29,000 individuals

Sample citations

- Restrictions on residential treatment for substance use disorders
- Impermissible annual limit
- Overly restrictive outpatient visit limits
- More restrictive financial requirements
- Lack of out-of-network coverage for MH/SUD
- Overly stringent precertification requirements
- Autism coverage under review

Strengthening Parity in MH/SUD Benefits

- Signed into law on December 27, 2020
- Requires group health plans to perform and document comparative analyses of the design and application of nonquantitative treatment limitations (NQTLs)
- Plans must be prepared to make these comparative analyses available to the Departments of Labor and/or Health and Human Services upon request beginning 45 days after the date of enactment (February 10, 2021)

Enforcement Priorities

- Department FAQs do not provide an exhaustive list of NQTLs regarding which the Departments may request the comparative analysis and reinforce the need to perform and document comparative analyses for all NQTLs imposed.
- In the near term, the DOL indicates that it expects to focus its enforcement efforts on:
  - Prior authorization requirements
  - Concurrent review requirements
  - Standards for provider admission to participate in a network (including reimbursement rates)
  - Out-of-network reimbursement rates

Parity Enforcement Findings and Correction

- Distinct process managed differently than routine audits
- Extremely short timeframes for response (7-14 days)
- Limited time to supplement response
- Requests for extensions denied
- Enforcement inquiries may include more than the stated “priority” topics
- Findings of noncompliance issued rapidly
- Approach to finding sufficient/insufficient corrective actions still unclear

Tips to Help Plan Sponsors Be Prepared

- Encourage compliance by vendors and administrators when implementing new programs or benefits
- Keep alert of regulatory changes, litigation and enforcement activities to resolve issues outside of the enforcement context
- Create compliant documents, internal processes, and internal compliance programs to support audit preparedness

No Surprises Act

Enacted December 27, 2020 as part of the Consolidated Appropriations Act, 2021, Public Law 116-260

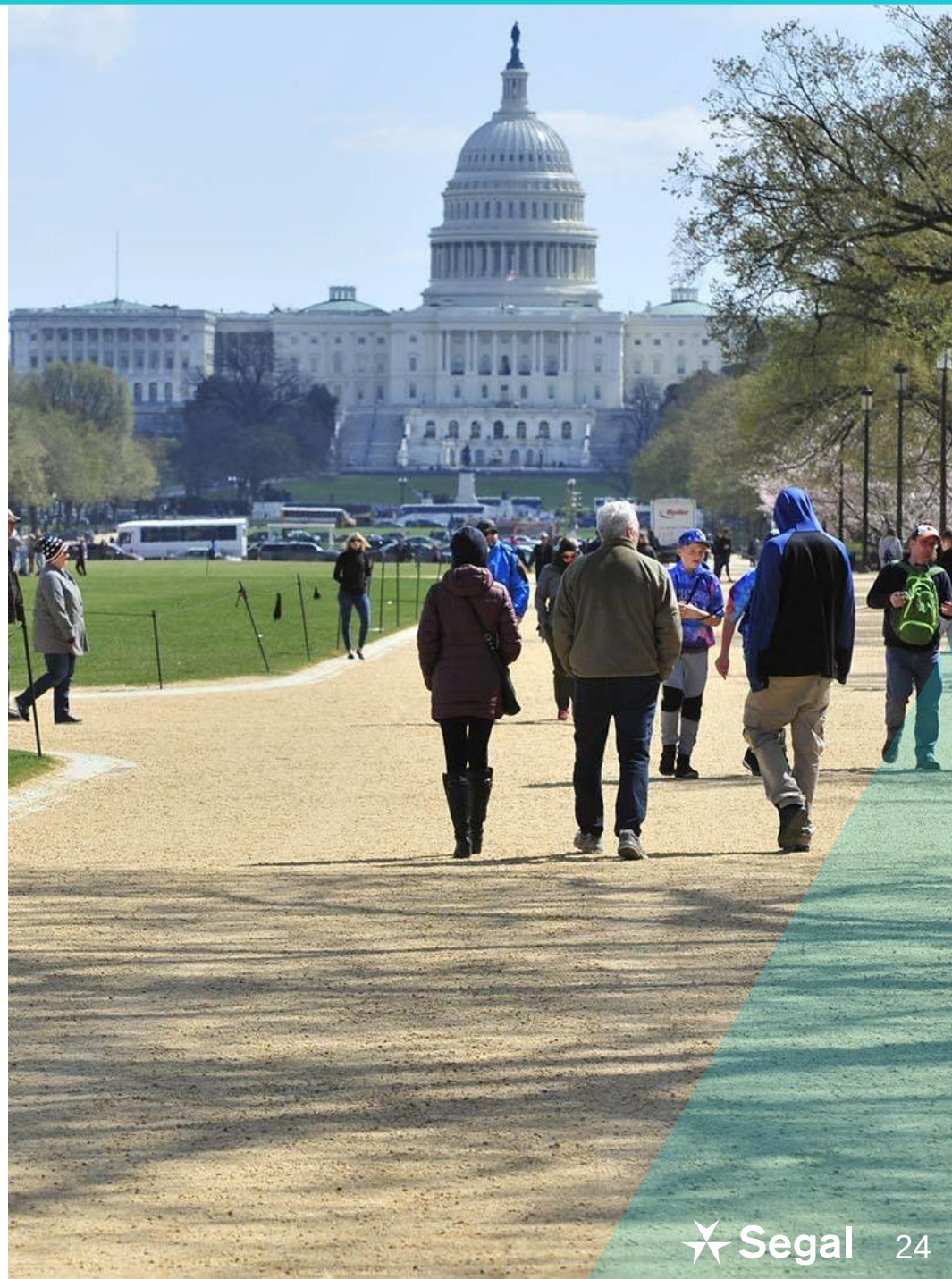
Applies to most group health plans and insurers, including grandfathered plans

Generally, effective for plan years beginning on or after January 1, 2022

Retiree-only plans, excepted benefits, Health Reimbursement Arrangements (HRAs) exempt

What's in the Interim Final Rule?

- Departments of Health and Human Services, Labor, and Treasury published an Interim Final Rule (IFR) on July 13, 2021 implementing Part I of the federal No Surprises Act (NSA)
- Rules likely to come later in 2021 on Federal Independent Dispute Resolution (IDR) process
- NCCMP has file multiple sets of comments on proposed and interim final regulations

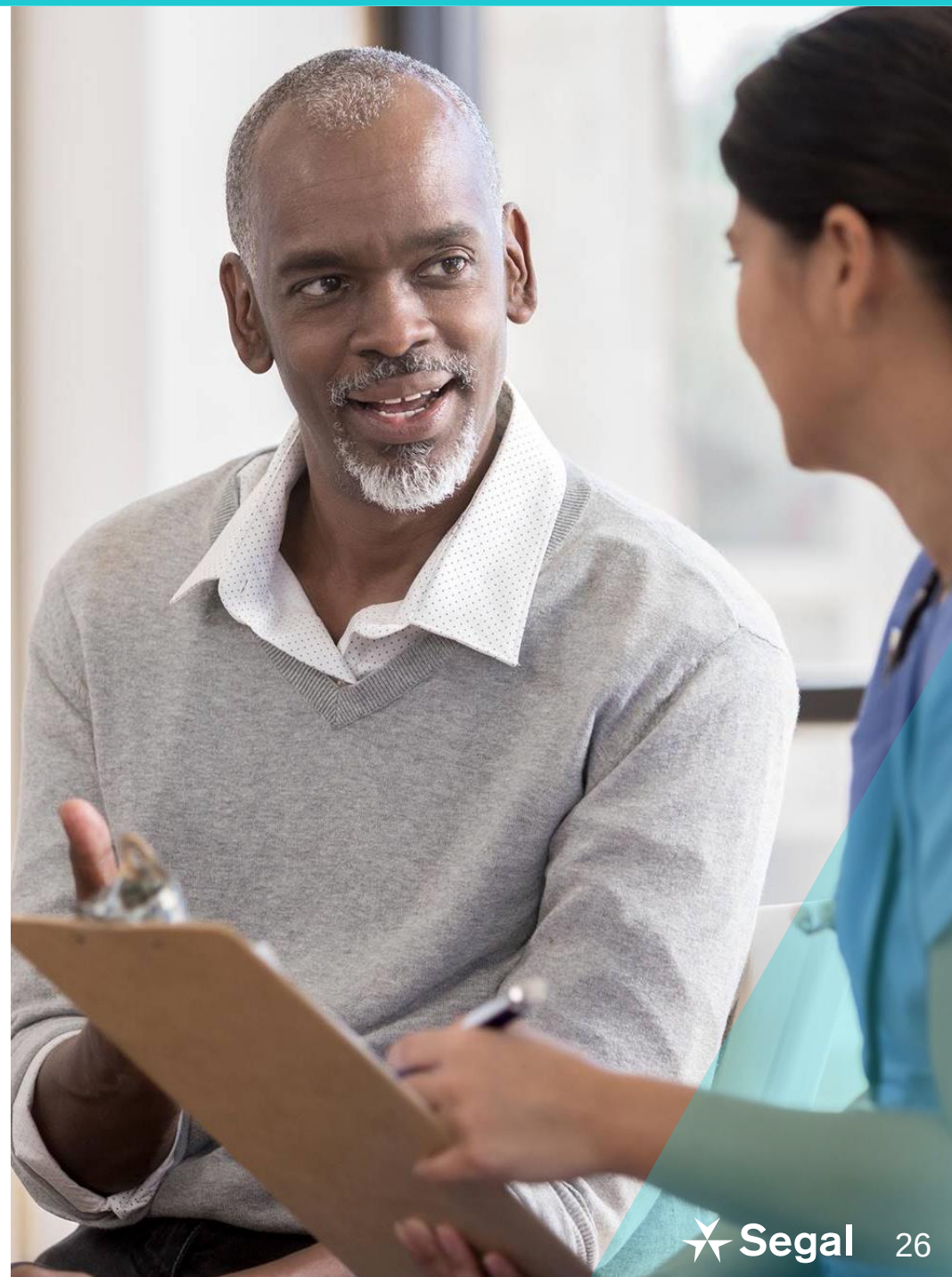


What Does the IFR Cover?

- Applicability of the No Surprises Act to group health plans
- Requirements that emergency services must be paid in the same manner both in and out of network
- Protection of participants against balance billing
- How to calculate the median in-network contracted rate used for both cost-sharing and calculating the Qualifying Payment Amount
- Rules prohibiting nonparticipating providers, facilities and air ambulance services from balance billing participants
  - Unless certain notice and consent requirements are satisfied

What Does the IFR Cover?

- Plan obligations to provide notices to participants
- Protections against air ambulance balance billing
- Extension of certain ACA patient protections to grandfathered health plans
- Establishment of new complaint process to address violations



New Guidance in FAQ #49

- FAQ #49 published August 20, 2021
- Delays, defers certain provisions of the transparency rule and No Surprises Act

Delayed until Future Rulemaking

- Prescription drug negotiated rate machine-readable file
  - Is it necessary? Litigation ongoing
- Prescription drug reporting (proposed rule)
  - Expected to begin on December 27, 2022 (instead of 2021) and each June 1 thereafter
  - NCCMP filed comments on request for information
- Advanced Explanation of Benefits
  - First HHS must issue rulemaking on how providers/facilities submit estimated charges

Deferred Enforcement

- In-network and out-of-network rate machine-readable files – July 1, 2022
- Price-comparison tool
  - Because similar to the Transparency Rule internet-based, self-service tool, same date will be used:
  - Plan years beginning on or after January 1, 2023 (with respect to 500 services)
  - January 1, 2024 (for the remaining items and services)

Plan sponsors are expected to implement the requirements using a good faith, reasonable interpretation of the law

No regulations before the effective date

Rules concerning the following likely will be issued in 2022

- ID cards
- Continuity of care
- Accuracy of provider network directories
- Prohibition on gag clauses

Plan sponsors must comply in good faith and based on a reasonable interpretation of the law.

Air Ambulance Reporting

- Departments proposed rule on Air Ambulance reporting requirements (September 10, 2021)
  - Proposal would require plans to report information on air ambulances for 2022 and 2023 plan years, by March 31, 2023 and 2024
  - Required data includes:
    - Plan name, market (insured, self-insured, etc.), date of service, provider name, CPT code, transport information, claim adjudication, and payment information
    - Includes data for claims received or paid during reporting period
  - Plan may delegate reporting to insurer or TPA
- Comments due October 18, 2021

Key Implementation Concerns for Multiemployer Plans

- Grandfathered plans must comply with most of the rules, including prudent layperson standard for emergency care
- Plans with joint administrative agreements have challenges coordinating implementation
- Plans with separate agreements for services (e.g., carve out benefits) and separate out-of-network pricing services must coordinate with them while still paying participant cost-sharing based on Qualifying Payment Amount
- Many plans do not have websites
- Extensive plan document amendments necessary

Questions?

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