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Top 10 compliance issues for health and leave benefits in 2021

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Health and leave benefit compliance issues for 2021

This year's twin health and economic crises caused by the COVID-19 pandemic continue to produce unprecedented challenges for employers in managing health and leave benefit offerings, contribution strategies, vendor terms, plan operations, future financial outlook, and employee communications. These challenges, along with public health and political uncertainties, make planning for 2021 more complicated than ever. This article summarizes the top 10 compliance developments to address or monitor when planning group health benefits and paid leave programs for the upcoming year.

Outlook, planning altered by COVID-19 pandemic

US policymakers have moved swiftly since the novel coronavirus outbreak began to provide aid that includes a wide range of new health and paid leave policies, and more changes are possible through this year into 2021. The important role of these programs figures prominently in congressional talks on the next recovery package that could pass this summer. Those negotiations, the divided Congress and an election-shortened legislative calendar dim the odds for major changes to the Affordable Care Act (ACA) and other initiatives unrelated to the pandemic and economic crises.

Meanwhile, President Trump and federal agencies are pressing forward with numerous regulatory proposals that predate the pandemic, including initiatives aimed at lowering prescription drug costs and improving the transparency of healthcare cost and quality information. However, legal challenges may stop some initiatives from taking effect before a potential change in administrations next year.

Congress

Employers should keep a close eye on the next COVID-19 relief package as negotiations between the Democrat-controlled House and the Republican-controlled Senate intensify over the coming weeks. Although the timing and contents of the package are up in the air, numerous health and paid leave proposals are in the mix, and some could land in a final bill. For example, COVID-19 relief legislation (HR 6800) that passed the House in May would create an array of new requirements extending through 2021, including:

- Fully subsidized continuation of employer-sponsored health coverage under the Consolidated Omnibus Budget and Reconciliation Act (COBRA) of 1985
- Eased restrictions on cafeteria plans and flexible spending arrangements (FSAs)
- Reinsurance for certain COVID-19-related costs incurred by employer plans

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- New health plan mandates
- Enhancement and extension of the health, emergency paid leave and other workplace programs enacted earlier this year

The House bill has no chance of enactment but provides a blueprint for negotiations with Senate Republicans and the White House on a final package. Achieving bipartisan consensus will be difficult, but enacting more relief may become a political imperative for both parties. Other policy priorities that could advance in a relief package include measures to end surprise medical bills, speed generic drugs to market, increase price transparency and enhance employers' ability to offer telehealth services.

Elections could bring new policy agenda

While structural changes to the ACA are not in the cards this year, healthcare is again a major campaign issue that bears watching for potential implications in 2021. Presumptive Democratic presidential nominee Joe Biden and many congressional Democrats are making ACA expansion a core tenet of their healthcare platforms. Biden is also proposing to lower the Medicare eligibility age and create a public option that could compete against private insurance plans. Biden has reached out to progressives and set up task forces that include top advocates of Medicare for All, an idea that has gained public support since the pandemic disrupted or ended coverage for many.

Enacting a public option or expanding Medicare will prove difficult in the next Congress even if Democrats keep control of the House and win the White House and the Senate. Besides intraparty disagreements, other obstacles include intense opposition to a public option by many employer groups and others in the healthcare industry. However, the pandemic's ongoing effects cloud the outlook and continue to raise difficult questions for many employers trying to maintain coverage and plan ahead for 2021. Close monitoring of health policy developments this year is especially important.

President Trump has yet to lay out a detailed healthcare agenda for the next four years. He has called for repealing the ACA, and his administration recently filed a Supreme Court brief supporting a lawsuit to eliminate the entire law (*California v. Texas,* 945 F.3d 355 (2019); *cert. granted,* No. 19-840 (U.S. March 2, 2020)). However, Republicans have not come up with an alternative. The administration so far has pursued regulatory initiatives aimed at unwinding parts of the law, lowering drug prices and requiring more price transparency. A second term could give Trump more time to battle the legal challenges that have beset his agenda and work with congressional Republicans on a broader plan.

Agencies

COVID-19 relief. Federal agencies have issued various forms of pandemic relief, and employers should monitor what additional relief may be needed or extended for next year. Possibilities include:

- Relief to allow carrying over balances in health and dependent care FSAs into 2021 — beyond the 2.5-month grace period now allowed for FSA carryovers and the $550 cap on health FSA carryovers

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- Continued ability to offer COVID-19 testing in an excepted-benefit employee assistance plan (EAP), even after the public health and national emergencies officially end
- ACA reporting relief for forms due in 2021

Regulatory changes to enhance the availability of telehealth, especially for behavioral healthcare, during the pandemic are expected to continue into 2021, with some made permanent. Guidance addressing return-to-work employer initiatives will evolve as the pandemic continues. COVID-19 legislation imposing the first federal paid leave requirement is scheduled to sunset at the end of this year. However, Congress could extend that mandate into 2021 and/or expand it to include large employers with more than 500 employees. Any extension or expansion will likely trigger more implementation guidance from the Labor Department's Wage and Hour Division.

Transparency. Agencies will advance key administration priorities like the transparency rules for group health plans and insurers, which probably will get finalized by year-end, with compliance potentially required by the first plan year starting one year after publication of the final rule. Similar transparency rules require hospitals to disclose information like payer-negotiated rates by Jan. 1, 2021, although a legal challenge to that rule is ongoing. Litigation and a potential change in administrations will impact how both transparency rules move forward.

Account-based plans. Transparency rules are just one item coming out of President Trump's June 2019 executive order on improving price and quality transparency in healthcare. Other guidance has aimed to promote the use of account-based plans and other alternative arrangements to pay for healthcare. Policy changes have eased predeductible coverage under high-deductible health plans (HDHPs) for the chronically ill who have health savings accounts (HSAs), increased health FSA carryovers, and proposed revised tax treatment of direct primary care arrangements (DPCAs) and healthcare sharing ministries. Initiatives in 2020 to expand employers' use of health reimbursement arrangements (HRAs) probably won't see much takeup in 2021, these alternative HRA designs might garner interest in future years, regardless of 2020 election results.

Data privacy and security. New information technologies (IT) allow quick access to data protected by the Health Insurance Portability and Accountability Act (HIPAA). As a result, health plan sponsors must evaluate each new IT vendor relationship for compliance with evolving guidance. Even if HIPAA doesn't apply, other federal and state data-protection and privacy laws may have implications for emerging health and wellness applications (apps) and software. While the new data interoperability rules taking effect in 2021 for health IT developers and healthcare payers and providers do not apply to employer group health plans, the resulting changes in how participants access their health data could have indirect effects on plans.

Ongoing ACA compliance. ACA rules will continue to play a large part in compliance activities for employer health plans. Continued enforcement of the employer shared-responsibility (ESR) and related reporting rules, updates to the summary of benefits and coverage (SBC) for 2021, handling of medical loss ratio (MLR) rebates from insurers, and continued payment of the Patient-Centered

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Outcomes Research Institute (PCORI) fee are just a few ongoing ACA compliance matters to keep in mind for 2021.

Wellness and mental health parity. While these issues are not among the top 10 compliance items for 2021, employers should continue to ensure their health plans meet wellness program requirements and mental health parity obligations, if applicable. Wellness programs will need review once the Equal Employment Opportunity Commission (EEOC) issues revised rules to replace its rescinded regulations on financial incentives in employer-sponsored wellness programs under the Americans with Disabilities Act (ADA) and Genetic Information Nondiscrimination Act (GINA). Enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) will get ongoing attention, with the Department of Labor (DOL) slated to finalize an updated draft 2020 MHPAEA self-compliance tool recommending that plans have a formal internal compliance program for mental health parity.

Courts

Action in the courts also has the potential to reshape benefits and program administration. The US Supreme Court's recent decision in *Bostock v. Clayton County, Ga.*, should trigger plan sponsors to evaluate how their benefit offerings for LGBTQ employees comply with federal sex discrimination protections under Title VII of the Civil Rights Act of 1964. This decision also has implications for the recently revised final nondiscrimination regulations under ACA Section 1557, which remove the transgender protections outlined in the 2016 final regulations.

The Supreme Court's decision in *Little Sisters of the Poor v. Pennsylvania* indicates that employers may be able to assert a religious or moral objection to providing contraceptive coverage as preventive-care benefits. However, ongoing litigation on the 2018 final regulations and the potential for a new administration to amend these rules in 2021 leave some uncertainty about these exemptions.

In the coming months, the justices will hear arguments in the latest challenge to overturn the entire ACA, with a decision likely in 2021 (*California v. Texas,* 945 F.3d 355 (2019); *cert. granted,* No. 19-840 (U.S. March 2, 2020)). Other ongoing legal challenges seek changes to specific ACA regulations, such as the association health plan (AHP) rules (*New York v. US Dep't of Labor*, No. 18-1747 (D.D.C. March 28, 2019)) and the hospital transparency rules (*Am. Hosp. Ass'n v. Azar*, No. 1:19-cv-03619 (D.D.C., June 23, 2020), *motion for expedited appeal filed* (D.C. Cir. July 3, 2020).

Employers should also keep an eye on recent litigation alleging plans and/or their vendors have violated benefit rules, such as COBRA notice requirements or mental health parity regulations.

States

COVID-19 and the related public health emergency sidelined states' agendas and drained their budgets. As 2021 approaches, states may look to health plan assessments as new funding sources for healthcare.

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The expected US Supreme Court decision on state regulation of pharmacy benefit managers (PBMs) could have broad implications for plan sponsors that rely on PBMs (*Rutledge v. Pharm. Care Mgmt. Assoc.*, 891 F.3d 1109 (2018); *cert. granted,* No. 18-540 (U.S. Jan. 10, 2020). Plan sponsors will need to work with PBMs to determine to what extent, if any, a given state's PBM standards may apply to a self-insured plan.

Although action on ACA Section 1332 innovation waivers has slowed during the pandemic, states will likely renew studying options to broaden health coverage, including individual mandates that require plan sponsor and insurer reporting. Employers will need to provide timely reports in 2021 for the existing individual-coverage mandates in California, Massachusetts, New Jersey, Rhode Island and Washington, DC. (Vermont also has an individual-coverage mandate, but the law currently does not require any employer reporting.)

2021 health and leave benefit planning

This list highlights 10 top compliance-related priorities for 2021 health and leave benefit planning and recommends general actions for each item. The links below take readers to more detailed information and resources related to each compliance priority:

1. **COVID-19 issues for group health plans.** COVID-19 considerations for group health plans will extend into 2021 if the public health emergency and related agency guidance remain in place past 2020 year-end or sponsors choose to keep certain benefits adopted during the pandemic. When strategizing for 2021, employers should review this year's coverage mandates, communications to plan participants and agencies' COVID-19 relief. Some employers may want to continue certain benefit enhancements beyond the required coverage period, while others may want to revert back to terms predating the pandemic. In either case, communications with plan participants and plan documentation is key. Opportunities to expand telehealth, EAPs and on-site clinics could continue into 2021.

2. **Transition back to a safe, healthy workplace.** Plan how to adapt and reset so at least some employees furloughed or telecommuting early in the pandemic can safely return to the workplace. Monitor local conditions, and prepare contingency plans as pandemic and economic conditions evolve. Stay focused on diversity and inclusion goals in light of the recent global protests for racial equality and a Supreme Court decision confirming civil rights protections for the LGBTQ employees. Recognize the need to have an individualized operating plan for 2021 that reflects local pandemic conditions while prioritizing employee safety, health, diversity and inclusion.

3. **Paid leave.** Assess employer-sponsored paid leave programs, including sick, disability, parental and family leave. Monitor state and local legislation for new or expanded leave mandates and programs, and track the status of emergency measures requiring paid leave for COVID-19 (or other public health emergencies) that may stretch into 2021. Evaluate processes for integrating COVID-19 paid leave requirements and nonemergency state and local paid leave mandates with existing benefit plans; revise plans as needed to comply. Multijurisdictional employers should consider

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developing a long-term strategy for equalizing leave benefits across jurisdictions and administering increasingly complex programs.

4. **State activity.** Review state laws raising concerns for group health plans. For insured plans, expect more activity on surprise medical bills and new benefit mandates for health insurers. State initiatives that could affect all employers include health plan reporting for individual-coverage mandates, PBM regulations, new or continuing health plan assessments, and expanded telemedicine laws. Employers should also track state innovation waivers under ACA Section 1332 to identify any restrictions that may affect plan design. Employers should work with vendors to ensure compliance with these initiatives.

5. **Prescription drug costs and coverage.** Review new payment models and plan designs aimed at lowering plan costs for gene therapies and specialty medications to ensure compliance with regulatory requirements. Monitor federal and state legal and other developments targeting the increasing cost of prescription drugs. Evaluate the impact of these changes on prescription drug benefits, and reassess health plans' drug-purchasing strategies.

6. **Transparency rules.** Review the final transparency regulation for hospitals, as well as the proposed rule for group health plans and insurers. Work with plan experts to review the prices that hospitals make public in 2021, under the final transparency rule. Prepare to comply with the transparency rule for group health plans and insurers, which may take effect in 2021 for noncalendar-year plans. Watch for litigation that may delay or invalidate these rules.

7. **Data privacy and security.** Evaluate each new tech vendor that has access to health and welfare plan data to determine whether the HIPAA or other data-protection and privacy laws apply. Wellness and transparency tools, mobile apps, and artificial intelligence may implicate HIPAA and other laws. Regularly review vendor compliance, since any breach or violation could implicate plan sponsor obligations under HIPAA, ERISA fiduciary rules or state law. Monitor how HIPAA guidance evolves to address not only the pandemic but emerging technologies. Track whether new healthcare data interoperability rules have an impact on information sharing in the private sector.

8. **HSA, HRA and FSA developments.** For 2021, ensure administrative practices comply with optional or required COVID-19 relief, and timely adopt any necessary plan amendments. Update HDHPs and account-based health plans for indexed dollar limits. Consider adding newly HSA-eligible preventive services to HDHP coverage and allowing reimbursement of over-the-counter (OTC) drug costs without a prescription and, if permissible, fees for DPCAs. Identify pre- or no-deductible health benefits, programs or point solutions that could jeopardize HSA eligibility, and determine whether to make changes. Now may also be the time to consider offering one of the new types of HRAs — an individual-coverage HRA or an excepted-benefit HRA. Monitor pending COVID-19 relief legislation that could provide greater FSA flexibility or enhance HSAs for 2021.

9. **Preventive services.** Confirm that nongrandfathered group health plans cover ACA-required in-network preventive services without any deductible, copay or other cost sharing. Modify

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preventive benefits for the 2021 plan year to reflect the latest recommendations from the US Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and ACA guidance. Adjust benefits for new or revised recommendations. Monitor development of COVID-19 preventive services or vaccines, which nongrandfathered health plans must cover without cost sharing on an expedited basis. Nongovernmental employers with sincerely held religious or moral objections to contraceptives may exclude ACA-mandated coverage of some or all women's contraceptives approved by the Food and Drug Administration (FDA), under final regulations recently upheld by the Supreme Court. Update plan documents, summary plan descriptions (SPDs), SBCs and other materials as needed.

10. **Other ongoing ACA concerns.** Review 2021 group health plan coverage and eligibility terms in light of ESR strategy, ESR and minimum essential coverage (MEC) reporting duties, and ACA benefit mandates. Determine whether the proposed grandfathered health plan rule, if/when finalized, will help preserve grandfathered status (if applicable). Use updated SBC templates for 2021 health plans. Continue to calculate and pay the PCORI fee, manage MLR rebates, and confirm the health insurance tax (HIT) is not built into 2021 premiums. Review potential sex discrimination concerns in benefit eligibility and plan terms in light of recent developments in federal nondiscrimination laws. Monitor ongoing litigation challenging the ACA and any congressional response, as the outcome will likely have implications for employer group health plans. Reconsider any benefit changes to minimize the Cadillac tax in 2022, since Congress repealed it in a federal spending package late last year.

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1

COVID-19 issues for health plans

Action

Review group health plan terms for COVID-19-related coverage, including testing, treatment and future vaccines. Consider benefit options for employees ineligible for the group major-medical plan and midyear election options for eligible employees who previously waived coverage. Communicate changes in plan terms, eligibility and election periods, and amend plan documents. Confirm proper administration of claims and appeals, HIPAA special enrollment events, and COBRA election periods and payments in light of agency relief extending deadlines during the public health emergency.

Specific steps

Confirm group health plan coverage complies with COVID-19 testing and preventive care mandates in the Families First Coronavirus Relief Act (FFCRA) (Pub. L. No. 116-127), as amended by the Coronavirus Aid, Relief and Economic Security (CARES) Act (Pub. L. No. 116-136), and any applicable state mandates.

- During the public health emergency, confirm group health plan coverage of COVID-19 testing and related services without any participant cost sharing, prior-authorization requirements or other medical-management standards whenever a licensed healthcare or otherwise authorized provider deems the testing medically appropriate (per agency guidance).
  - Verify these coverage standards apply to COVID-19 testing and related services from both in- and out-of-network providers.
  - Confirm coverage extends to testing and related services conducted in nontraditional settings, like drive-through facilities or at home, in addition to urgent care centers, emergency rooms and telehealth consultations.
  - Watch for additional agency guidance that could provide more clarity around the FFCRA's COVID-19 testing coverage mandate or future legislation amending this provision.
  - Separate agency guidance (IRS Notice 2020-15) provides that HDHPs can cover COVID-19 testing and treatment on a predeductible basis, without affecting a participant's eligibility for HSA contributions, until further notice. (For more on predeductible COVID-19 coverage in HDHPs, see HSA, HRA and FSA developments.)

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- For fully insured plans, confirm compliance with state COVID-19 coverage requirements that may be more expansive than the federal requirements. For example, some states require coverage of COVID-19 treatment without cost sharing.
  - According to the Centers for Medicare & Medicaid Services (CMS), COVID-19 diagnosis and treatment are ACA essential health benefits (EHBs) covered by all state benchmark plans.
- Consider whether the plan will cover COVID-19 testing and related services when conducted for general workplace or back-to-school screenings or in other circumstances (e.g., travel) that are not subject to a federal or state mandate or cost-sharing ban. (For more on back-to-work strategies, see Transition back to a safe, healthy workplace.)
- Confirm plan coverage of COVID-19 vaccines without cost sharing within 15 days after the ACIP or the USPSTF recommends a vaccine or other preventive service. (For more on preventive care requirements, see Preventive services.)
  - Unless done earlier, consider communicating the plan's coverage of COVID-19 vaccines without cost sharing (and amending plan terms accordingly) in advance of the coverage requirement.
  - COVID-19 vaccines will be considered preventive care that HDHPs can cover on a predeductible basis without affecting eligibility for HSA contributions.

Review group health plan communications about COVID-19 coverage.

- Decide whether to adopt plan amendments to memorialize COVID-19 coverage changes to plan terms, even if those changes were temporary and already communicated to participants. Plan amendments normally must be adopted before the last day of the plan year to which they apply, absent guidance extending the deadline. In some cases, a summary of material modifications (SMM) can serve as the plan amendment.
- Consider whether the plan will continue to cover COVID-19 testing and related services without cost sharing once the public health emergency has ended. If covering COVID-19 treatment without cost sharing, consider whether coverage terms will remain the same after the public health emergency expires.
  - If coverage terms will revert back after the public health emergency expires, prepare communications to distribute at least 60 days in advance of the reversal, unless previous communications indicated the general duration of the additional covered services and reduced cost sharing.
  - If coverage enhancements will continue beyond the public health emergency period, confirm by amending plan documents and communicate those changes to employees (e.g., with the SBC, SMM or SPD).

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Consider expanding telehealth, EAPs and on-site clinic benefits.

- Explore offering a stand-alone telehealth program to employees ineligible for the group health plan so they can obtain care during the pandemic. For telehealth plan years beginning before the end of the public health emergency, agency guidance provides relief from many ACA group market reforms for large employer-sponsored telehealth programs offered to employees ineligible for any other employer group health plan.
  - Review compliance considerations with counsel, as certain ACA and ERISA requirements will still apply to stand-alone telehealth programs.
  - If adopting a stand-alone telehealth program, develop a strategy for when temporary relief from specific ACA group market reforms expires, unless regulators provide more permanent relief.
- Consider expanding services available through a telehealth plan. The CARES Act allows HDHPs to cover telehealth services on a predeductible basis and provides that telehealth coverage outside of a HDHP will not jeopardizing HSA eligibility. This safe harbor is available for plans beginning on or before Dec. 31, 2021 (see HSA, HRA and FSA developments).
- Consider expanding the EAP to add COVID-19 diagnostic and testing services. Agency guidance confirms that an excepted-benefit EAP can offer COVID-19 diagnostic and testing services while the public health or national emergency is in effect.
  - Make sure to discontinue any COVID-19 diagnostic and testing services added to the EAP once the COVID-19 emergency period ends. Otherwise, the EAP could lose excepted-benefit status if those services are considered significant medical care benefits.
- Consider expanding on-site medical clinic benefits. Agency guidance confirms that employer-sponsored on-site medical clinics are excepted benefits in all circumstances, so employers can readily expand the range of services offered. Consider providing COVID-19 testing and treatment (if practical), among other services, through an on-site clinic to all employees.

Adopt cafeteria plan amendments for changes based on IRS COVID-related relief, even if the changes are temporary.

- Cafeteria plan amendments must be adopted on or before Dec. 31, 2021, if the plan acted on IRS relief allowing midyear changes to certain health coverage elections during calendar-year 2020, regardless of the normal restrictions under Section 125 of the tax code. The amendment can be retroactive to the first day of the plan year beginning on or after Jan. 1, 2020.
- Self-insured group health plans allowing midyear election changes consistent with the IRS relief should confirm objectives with stop-loss carriers, if not done already.

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Review administration of delayed COBRA elections or premium payments, HIPAA special enrollment elections, and benefit claims and appeals. Make corrections where necessary.

- Ensure plan participants and COBRA-qualified beneficiaries have an extended period during the COVID-19 emergency to meet certain time-sensitive tasks, such as electing HIPAA special enrollment or COBRA coverage, paying COBRA premiums, and filing benefit claims or appeals. Agency COVID-19 guidance requires plans to pause counting down the time periods for completing these participant actions during the outbreak period (March 1 through 60 days after the end of the COVID-19 national emergency).

- Verify that extended deadlines have been communicated to plan participants and COBRA beneficiaries. Ask vendors whether they are communicating the extended timing requirements in claim denial notices, explanation of benefits (EOBs), as well as HIPAA and COBRA notices during the outbreak period. Review and amend plan documents and SPDs as necessary.

- Confirm that health plan administrators are properly accommodating participants eligible for HIPAA special enrollment after March 1 and allowing plan participants and beneficiaries extra time to file benefit claims and appeals or to request external review of a denied claim.

- Check that COBRA administrators are properly accommodating delayed elections or premium payments during the outbreak period. Increased COBRA-related litigation makes improper administration a heighted compliance risk.

  - Employer plan sponsors should consider consulting with legal counsel and the plan's COBRA administrator, claims administrator and/or stop-loss carrier to ensure compliance with claim-processing and COBRA premium-payment regulations during the outbreak period. Confirm responses to provider inquiries about COBRA status are handled in a timely and consistent manner.

- Confirm COBRA election notices are provided in a timely manner, despite the relief allowing plans extra time to distribute. Delays in distributing COBRA election notices may further extend the period during which qualified beneficiaries can elect coverage, complicating administration even more.

  - Updated model COBRA general and election notices from DOL do not address the COVID-19-related relief. To reduce the litigation risk for insufficient notices, health plan sponsors may want to use the most recent models but add information about the extended timelines during the outbreak period.

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Confirm compliance with ERISA notice and disclosure requirements, both during and after the outbreak period.

- COVID-19 agency guidance allows plan sponsors to comply with any ERISA required notice and disclosures "as soon as administratively practicable under the circumstances" during the outbreak period. The guidance also allows plan sponsors to use electronic-delivery methods, such as text messages, emails or websites, as long as it is reasonable to believe recipients can easily access those means of communication.
- Resume normal ERISA notice and disclosure distribution methods after the outbreak period, and limit electronic distributions to circumstances that satisfy the DOL's electronic safe harbor rules to reduce compliance risk.

Watch for additional COVID-19 relief legislation that could affect employer benefits in 2021.

- Future recovery packages could include COBRA subsidies, require group health plan coverage of COVID-19 treatment without cost sharing, offer a reinsurance program for employer COVID-19-related costs and ban balance billing for virus treatment.
- Employers should monitor developing legislation and prepare to adjust employee benefits and plan administration as necessary.

Related resources

Non-Mercer resources

- State action related to COVID-19 coverage of critical services by private insurers (The Commonwealth Fund, July 6, 2020)
- ACA FAQs, part 43 (DOL, Department of Health and Human Services (HHS), and Treasury, June 23, 2020)
- Notification of relief, Extension of certain timeframes for employee benefit plans, participants and beneficiaries affected by the COVID-19 outbreak (Federal Register, May 4, 2020)
- Disaster relief notice 2020-01 (DOL, April 29, 2020)
- ACA FAQs, part 42 (DOL, HHS and Treasury, April 11, 2020)
- Pub. L. No. 116-136, the CARES Act (Congress, March 27, 2020)
- Pub. L. No. 116-127, the FFCRA (Congress, March 18, 2020)
- FAQs on EHB coverage and COVID-19 (CMS, March 12, 2020)

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- Notice 2020-15, HDHPs and expenses related to COVID-19 (IRS, March 11, 2020)

Mercer Law & Policy resources

- IRS offers relief to cafeteria plans, HDHPs, individual-coverage HRAs (May 28, 2020)
- IRS, DOL ease deadlines for health, other benefit plans and participants (May 27, 2020)
- House aid bill aims to boost health benefits, COVID-19 leave, retention (May 21, 2020)
- Keeping track of COVID-19 laws affecting employee benefits, jobs (May 4, 2020)
- Employer health plans have to meet new COVID-19 coverage mandate (April 21, 2020)
- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)
- COVID-19 spurs IRS relief for HDHPs, state insurance guidance (March 18, 2020)
- Virus aid legislation includes cost-sharing curbs, new leave rights (March 18, 2020)

Other Mercer resources

- Stay informed on the coronavirus (regularly updated)
- Use the telemed safe harbor while it lasts (July 6, 2020)
- Protect job-based healthcare (June 4, 2020)
- Extended timeframes for plan disclosures and elections, including COBRA and HIPAA (May 7, 2020)
- COBRA support needed for American workers (April 30, 2020)
- Mid-plan-year health benefit options for nonparticipants (April 9, 2020)
- COVID-19 and health plan experience: A framework for developing cost projections (April 2, 2020)
- Healthcare items in the mix for 'phase 4' COVID-19 relief package (April 2, 2020)
- Waive member cost sharing for COVID-19 treatment — or not? (April 2, 2020)
- COVID-19 and employer-sponsored clinics (March 20, 2020)
- Call me, ping me if you want to reach me: The importance of telehealth in fighting COVID-19 (March 12, 2020)

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2

Transition back to a safe, healthy workplace

Action

Prepare or update operating plans for 2021 after closely reviewing local conditions and federal, state and local COVID-19 guidance. Consider not only employee health and safety, but also diversity and inclusion goals. Recognize specific guidelines will vary, depending on the size and type of employer, workforce, industry, working conditions, budget and local pandemic conditions, including whether schools and childcare are open. Decide whether to screen or test employees for COVID-19, and prepare to respond when an employee shows symptoms or tests positive. Ensure benefit programs help employees and their families meet their health (including behavioral health) and financial wellness needs. Regularly review the efficacy of operating plans, stay updated on new guidance, consult with experts as needed and have contingency plans for changing conditions.

Specific steps

Regularly review federal, state and local workplace safety and health guidance, and consult with experts as needed. Pay attention to state and local guidelines, which may require screening workers with temperature checks or a health questionnaire or checklist. Plan to revisit all guidance for updates as the pandemic rapidly evolves. Here are some key federal pandemic resources to help employers navigate workplace issues:

- **CDC.** The CDC provides information for businesses and workplaces to plan, prepare and respond to COVID-19, including health and safety steps for specific occupations. Special rules likely apply to employers with healthcare, long-term care, assisted living or nursing home workers; first responders; or law enforcement personnel. Important resources for reopening workplaces include:
  - Resuming business toolkit
  - FAQs for businesses
  - Testing in non-healthcare workplaces

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- **OSHA.** The Occupational Safety and Health Administration (OSHA) has developed a COVID-19 medical information webpage and COVID-19 FAQs to help employers protect their workers and comply with OSHA requirements during the COVID-19 pandemic. Resources available include:
  - Guidance on preparing workplaces for COVID-19 (Spanish version)
  - Worker exposure risk to COVID-19 (Spanish version)
  - Prevent worker exposure to coronavirus (COVID-19) (Spanish version)
  - COVID-19 guidance for retail workers (Spanish version)
  - Relevant OSHA standards for COVID-19
  - Temporary enforcement guidance during the COVID-19 pandemic

Review federal, state and local guidance on workplace anti-discrimination rules, particularly as they relate to the pandemic. Ensure workplace practices do not discriminate against job applicants or employees because of their race, color, religion, sex (including pregnancy, gender identity and sexual orientation), national origin, age (40 or older), disability, or genetic information. Comply with other federal, state and local laws that may provide additional protections.

- The EEOC is responsible for enforcing these federal laws on workplace anti-discrimination:
  - The ADA and the Rehabilitation Act require nondiscrimination toward and reasonable accommodations for applicants and employees with disabilities. The laws also restrict employee medical exams and inquiries.
  - Title VII of the Civil Rights Act prohibits discrimination based on race, color, national origin, religion and sex (including gender identity, sexual orientation and pregnancy).
  - The Age Discrimination in Employment Act prohibits age discrimination against workers 40 or older.
  - GINA prohibits discrimination based on genetic information, including family medical history.
- Important EEOC resources related to the pandemic include:
  - **Pandemic preparedness in the workplace and the Americans with Disabilities Act.** This resource, while subject to change as conditions evolve, provides guidance on a number of important questions, including:
    - *How much information from an ill employee may an employer request to protect the rest of its workforce during a pandemic?* Employers may ask employees who report feeling ill at work or call in sick about their symptoms to determine if they have or may have COVID-19.

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Relevant symptoms currently include, for example, fever, chills, cough, shortness of breath or sore throat.

- *When may an ADA-covered employer take employees' body temperature during a pandemic?* Because the CDC and state/local health authorities have acknowledged community spread of COVID-19, employers may measure employees' body temperature. Like all medical records, information about an employee's fever or other symptoms would be subject to ADA confidentiality requirements.

- Does the ADA allow employers to require employees to stay home if they have COVID-19 symptoms? Yes, an employer can send an employee with COVID-19 or symptoms home.

- *When employees return to work, does the ADA allow employers to require doctors' notes certifying fitness for duty?* Yes, employers may impose these return-to-work requirements because they either are not disability-related inquiries or, due to the severity of the pandemic, are justifiable disability-related inquiries under the ADA standards.

— **What you should know about COVID-19 and the ADA, the Rehabilitation Act, and other EEO laws.** This resource includes FAQs about confidential screening and testing employees for COVID-19 and other important information, including:

- *May an employer require antibody testing before permitting employees to reenter the workplace?* No, an antibody test is a medical examination under the ADA. In light of CDC's interim guidelines that antibody test results "should not be used to make decisions about returning persons to the workplace," an antibody test at this time does not meet the ADA's "job-related and consistent with business necessity" standard for subjecting employees to medical examinations or inquiries. However, COVID-19 viral tests are permissible under the ADA. EEOC will continue to closely monitor CDC recommendations and could update this discussion in response to changes.

- *Could reasonable accommodations, absent undue hardship, offer protection to an employee at higher risk from COVID-19 due to a preexisting disability?* Yes, some temporary accommodations may meet an employee's needs, without causing undue hardship for the employer. Low-cost solutions using materials already on hand or easily obtained may be effective. If not already implemented throughout the workplace, accommodations for employees with disabilities who request reduced contact with others may include changes to the work environment, such as designating one-way aisles; using plexiglass, tables or other barriers, whenever feasible per CDC guidance, to ensure safe distances between customers and coworkers; or making other modifications that reduce chances of exposure.

- The US Department of Justice provides additional ADA resources and guidance on ADA.gov.

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Review federal, state and local guidance on COVID-19 leave and other leave laws, including mandated sick leave, leave to care for a family member or quarantine leave.

- The DOL's Wage and Hour Division has provided guidance on pandemic-related issues, including:
  - COVID-19 and the American workplace
  - COVID-19 and the Fair Labor Standards Act
  - Families First Coronavirus Response Act Q&As (for employers with less than 500 employees)
- Monitor state and local leave guidance, using references like Mercer's regularly updated GRIST, States, cities tackle COVID-19 paid leave. For more details, see the Paid leave section.

Monitor local conditions using tools like Oliver Wyman's COVID-19 Pandemic Navigator, and stay on top of local workplace guidelines and restrictions.

- Review any local restrictions due to the pandemic, such as stay-at-home or shelter-in-place orders, or shutdowns or restrictions affecting certain businesses, mass transit, schools and daycare centers. Employees may need to have flexible schedules or to work remotely because of these limitations.

Develop and implement a plan for returning to a safe, healthy, diverse and inclusive workplace in 2021, after reviewing local pandemic conditions and all relevant guidance. Consider these steps:

- Make changes to physical workspaces (e.g., social distancing and restricted use of common spaces), hygiene practices (e.g., cleaning and disinfecting), health and other employee benefit plans (see COVID-19 issues for health plans), paid and unpaid leave (see Paid leave), flexible work schedules, technology, and the overall size of the workforce or the number of workers on site at any particular time (create cohorts of workers). Revisit these changes often, and continue to review conditions and guidelines that may require additional changes.
- Consider screening or testing employees for COVID-19 while complying with confidentiality requirements, and prepare to respond if or when an employee is symptomatic or tests positive.
  - Current agency guidance says that federal law requiring coverage of medically appropriate COVID-19 testing without cost sharing does not require COVID-19 screening for general workplace health and safety (as part of a return-to-work program, for example), public health surveillance, or any purpose other than individualized diagnosis or treatment. As a result, group health plans don't have to pay for return-to-work testing. However, self-funded employer plans probably can cover COVID-19 testing for return-to-work purposes, and state laws may require insured plans to cover testing for certain workforces (e.g., healthcare or nursing home workers).
  - Do not conduct antibody testing of employees, since this is not permitted under the ADA (see discussion above).

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- Develop a plan for managing an employee who shows symptoms or tests positive for COVID-19, including contact tracing and quarantining co-workers who may have been exposed.
- Require employees to wear face masks or use other personal protective equipment (PPE).
- Limit business travel to meet with clients, customers and colleagues by holding virtual meetings.
- Review issues for remote workers, including tax and other compliance issues, cybersecurity protocols, and other technology matters.
- Update policies and procedures to ensure compliance with all anti-discrimination laws. If operating in a jurisdiction that mandates ongoing training to prevent sexual harassment or other discrimination, make sure your program is accessible to remote workers. Consider adding mandatory training on various issues (e.g., unconscious bias) and making other changes to promote diversity and inclusion. Review practices to support remote workers (including issues like video conferencing and childcare) and to provide ADA accommodations to employees whose disabilities create high risk for COVID-19.

Develop contingency plans, debrief often and decide whether to course correct as conditions change. Prepare continuity plans for future outbreaks.

Related resources

Non-Mercer resources

- Coronavirus (COVID-19) website (CDC)
- COVID-19 website (OSHA)
- Coronavirus and COVID-19 website (EEOC)
- COVID-19 and the American workplace (DOL Wage and Hour Division)

Mercer Law & Policy Resources

- Roundup: COVID-19 resources for employers (regularly updated)
- States, cities tackle COVID-19 paid leave (regularly updated)
- Justices' Title VII ruling on LGBTQ bias has health benefit impacts (June 15, 2020)
- Keeping track of COVID-19 laws affecting employee benefits, jobs (May 4, 2020)
- DOL and IRS issue guidance on COVID-19 emergency paid leave (April 29, 2020)

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- Employer health plans have to meet new COVID-19 coverage mandate (April 21, 2020)
- CARES Act expands unemployment benefits, aims to stem job losses (April 15, 2020)
- COVID-19 raises HIPAA privacy, security issues (April 6, 2020)
- COVID-19 spurs IRS relief for HDHPs, state insurance guidance (March 18, 2020)

Other Mercer resources

- Stay informed on coronavirus (regularly updated)
- Return to a new normal (June 2020)
- Worksite employee COVID-19 testing covered by insurance? Not so fast! (July 16, 2020)
- Tough issue arising as workers return: At-risk employees and the ADA (July 16, 2020)
- Minority mental health month — a time for employer actions (July 9, 2020)
- Open enrollment communications: Reaching & engaging employees during COVID-19 (July 7, 2020)

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3

Paid leave

Action

Assess current paid leave programs, including sick, disability and parental/family leave. Evaluate existing plans against any relevant federal, state and local paid leave mandates, including any emergency COVID-19 leave laws that extend into 2021, and revise plans as needed. Monitor legislative and regulatory developments to prepare for new or expanded paid leave mandates and programs. Multijurisdictional employers should consider creating a long-term strategy to equalize leave benefits across jurisdictions and administer increasingly complex programs.

Specific steps

Review current leave policies and programs.

- Sort through which employees qualify for employer-sponsored paid time-off (PTO) plans and when.
- Identify where current leave plans and policies overlap with each other, any applicable state or local leave law, and emergency leave requirements at the federal, state and local levels.

Comply with all relevant paid sick and safe leave mandates.

- Conduct an organizationwide census to determine which employees are affected by state or local laws mandating paid sick and safe leave, including emergency paid leave.
- Analyze how relevant laws align with and differ from each other, emergency leave requirements and existing sick/PTO policies.
- Decide whether to integrate some or all leave policies across jurisdictions or add separate policy provisions in each region to reflect state or local mandates.
- Work with payroll or human resource information systems to comply with leave accrual, tracking and disclosure requirements.
- Provide appropriate written leave policies and notices to existing employees and new hires.

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Coordinate with state paid family and disability leave programs.

- Learn which state programs apply to employees in each work location.
- Evaluate how state programs overlap with federal emergency leave requirements and existing leave policies.
- Work with vendors to provide offsets and streamline coordination of state programs with unpaid leave under the federal Family and Medical Leave Act (FMLA) and employer leave policies.
- Distribute employee notices and disclosures as required by state law.

Develop strategy for administering paid leave benefits across jurisdictions with different mandates.

- Confirm that paid and unpaid leave benefits run concurrently where required and appropriate.
- Note where a state's mandated leave eligibility, definitions (e.g., family) or permitted uses differ from the provisions under employer-sponsored programs or the federal FMLA.
- Confirm compliance with federal FMLA requirements, including timely notice and tracking of leave taken.
- Consider developing a long-term strategy to equalize leave benefits and administer increasingly complex programs across jurisdictions. Review the pros and cons of using a third-party administrator (TPA) for administration.
- Consider getting involved in advocacy at the state level to harmonize emerging paid leave laws.
- Watch for federal developments, including new leave legislation or extension of federal emergency paid leave for COVID-19 or the paid family and medical leave tax credit.

Related resources

Non-Mercer resources

- State paid family leave insurance laws (National Partnership for Women and Families)
- Paid family leave resources (National Conference of State Legislatures (NCSL), April 16, 2020)
- Paid sick leave (NCSL, April 9, 2020)
- Family and Medical Leave Act Employer Guide (DOL, April 20, 2018)

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Mercer Law & Policy resources

- States, cities tackle COVID-19 paid leave (regularly updated)
- Washington, DC's paid leave program starts July 1 (June 10, 2020)
- California appeals court examines unlimited vacation policies (May 21, 2020)
- Roundup of selected state health developments, first-quarter 2020 (April 22, 2020)
- New York passes paid sick leave mandate (April 9, 2020)
- 2020 state paid family and medical leave contributions and benefits (Feb. 14, 2020)
- Massachusetts readies for paid family and medical leave (Jan. 13, 2020)
- Connecticut enacts paid family and medical leave (Aug. 29, 2019)
- ME, NV paid accrued leave mandates expand state paid sick leave law totals (July 1, 2019)

Other Mercer resources

- Life, absence & disability
- Designing a COVID-19 emergency leave policy: Four key considerations (March 17, 2020)
- Update: Rapid action plan on paid leave during the pandemic (March 12, 2020)
- COVID-19 and paid leave: Three scenarios to plan for (March 5, 2020)
- Think globally, comply locally: How employers navigate leave laws (Nov. 15, 2018)

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4

State activity

Action

Confirm health plan processes are in place to comply with applicable state and local reporting obligations. Track state legislation to impose new or modify existing health plan reporting obligations and assessments, as well as telemedicine laws. Work with carriers and vendors to ensure compliance with any new coverage mandates.

Specific steps

Work with vendors to strengthen compliance.

- Establish a process for complying with reporting requirements, including states' individual-coverage mandates, the Massachusetts health insurance responsibility disclosure and San Francisco's Health Care Security Ordinance.
- Work with TPAs and actuaries to calculate the cost of complying with state coverage-reporting requirements and assessments that apply to self-insured plans. Reporting obligations may include state individual-coverage mandates, play-or-pay assessments, healthcare expenditures, or other health plan details.
- Verify PBM contracts align with new state PBM laws and regulations, and determine to what extent those state provisions affect self-insured ERISA plans.
- As states broaden access to telemedicine, consider expanding telehealth benefits, especially for behavioral health. Use of telemedicine for mental healthcare may increase as more states join the Psychology Interjurisdictional Compact (PSYPACT), an initiative that facilitates the cross-state practice of telepsychology and temporary in-person, face-to-face psychology.

Work with carriers to address state initiatives affecting insured plans.

- Ask about the impact on premium costs resulting from state actions, such as consumer protections from surprise medical bills, new or expanded health coverage mandates, and plan surcharges or assessments — such as the ones in some states with ACA Section 1332 innovation waivers.
- Confirm the plan's state of issue (situs), and determine whether new insurance provisions apply in other states where employees work or reside.

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Related resources

Non-Mercer resources

- Section 1332: State innovation waivers (CMS)
- State individual mandates (USC–Brookings Schaeffer Initiative for Health Policy, October 2018)
- Opportunities and barriers for telemedicine in the U.S. during the COVID-19 emergency and beyond (Kaiser Family Foundation, May 11, 2020)
- PSYPACT

Mercer Law & Policy resources

- Massachusetts sets dollar limits for individual-mandate coverage (June 19, 2020)
- Roundup of selected state health developments, first-quarter 2020 (April 22, 2020)
- New York announces 2020 HCRA covered-lives assessment rates (Jan. 21, 2020)
- Massachusetts employers' health coverage reports due by Dec. 15 (Nov. 13, 2019)
- Vermont reissues employer health plan assessment reporting guidelines (Sept. 24, 2019)
- DC details employer reporting for individual health coverage mandate (Aug. 20, 2019)
- California individual health coverage mandate includes employer reporting (July 16, 2019)
- New push for ACA innovation waivers aims to rekindle states' interest (May 21, 2019)
- New Jersey posts update on health-coverage reports due in 2020 (April 16, 2019)
- San Francisco's annual health care expenditure report due April 30 (March 26, 2019)
- New York announces 2019 HCRA covered-lives assessment rates (Jan. 22, 2019)

Other Mercer resources

- Employers urge policy changes as Senate panel examines telehealth issues (June 25, 2020)
- Call me, ping me if you want to reach me: The importance of telehealth in fighting COVID-19 (March 12, 2020)
- Grab some ibuprofen: State mandates may create reporting headaches (June 20, 2018)

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5

Prescription drug costs and coverage

Action

Evaluate current plan designs and vendor offerings aimed at lowering prescription drug costs for compliance. Monitor federal and state law initiatives targeting specific medications or innovative payment strategies, and assess the potential impact on your group health plan.

Specific steps

Review newly available plan designs or payment models developed to cover very high-cost prescription drugs like gene therapies.

- Evaluate whether new offerings in the private marketplace — such as programs that prefund high-cost claims for new breakthrough medications — work for HDHP participants who have HSAs. Make sure plan materials explain any alternative payment arrangement that affects what a participant pays.
- Before agreeing to participate in these programs, review the payment structure with financial experts to make sure the plan has prudently weighed the program's net cost against the prevalence of the condition treated by the medication, as well as treatment outcomes.

Decide whether to exclude any manufacturer discount or coupon for brand-name medications from counting toward the out-of-pocket maximum (OOPM), as permitted by a final rule effective in 2021 for nongrandfathered group health plans.

- Review legal risks under the plan's existing copay cost-crediting policy (such as a copay accumulator program) for brand-name medications. Plans now have the flexibility to determine whether to include or exclude drug manufacturers' direct support from the ACA's OOPM, regardless of whether a medically necessary generic equivalent is available. However, insured plans will need to comply with state drug-coupon laws or regulations that may differ from the federal rule.
- Note that IRS rules for HSAs might not allow these amounts to count toward an HDHP's annual deductible. IRS has not issued guidance on how copay accumulator programs impact HSA standards, including whether drug coupon amounts can count toward the deductible without

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affecting an individual's HSA eligibility. HDHP sponsors should review copay accumulator programs with counsel.

- Update the health plan's SBC and SPD to address the treatment of drug manufacturer coupons and, if applicable, how the copay accumulator program works.

Monitor state drug reforms that could apply to your group health plan. Consider how legal challenges to private-sector prescription drug payment practices could affect your pharmacy program.

- Track states' cost-control initiatives that could affect drug expenses, purchasing options and vendor practices. These initiatives typically target drug manufacturers, PBMs and carriers providing insured benefits, but unless preempted by ERISA, the impact could extend to self-insured plans.

- Watch for oral arguments this fall and a decision in 2021 in a US Supreme Court case that will review whether ERISA preempts a state law regulating how PBMs set rates for certain generic medications. In *Rutledge v. Pharmaceutical Care Management Association*, the court will evaluate an Arkansas law similar to several other states' laws that seek to regulate the price that PBMs will pay pharmacies for specific generic drugs. This case involves just one type of state drug-pricing reform, but the decision could affect whether and how a whole range of state prescription drug laws apply to employer-sponsored plans.

- Stay up to speed with other litigation challenging pharmacy industry practices. The courts continue to see challenges under antitrust and other laws alleging industry efforts to thwart price competition have resulted in exorbitant prescription drug costs. In one recent case, a complaint filed by 51 states and territories alleges that certain generic drug manufacturers illegally inflated the price of medications (*Connecticut v. Sandoz*, No. 3:20-cv-00802 (D. Conn. filed June 10, 2020)).

Review federal prescription drug reforms that could drive changes or shift costs to the private sector.

- Assess the Trump administration's initiatives on prescription drugs. While most of those proposals apply only to Medicare or Medicaid, some involving transparency directly apply to group health plans. For example, a proposed regulation that could be finalized this year would require that group health plans and insurers publicly disclose their negotiated prices for all items and services, including prescription drugs. A federal district court recently upheld a similar transparency rule that applies to hospitals (*Am. Hosp. Ass'n v. Azar*, No. 1:19-cv-03619 (D.D.C. June 23, 2020)), but an appeal is pending. However, a federal appeals court recently struck down separate regulations that would have required drug manufacturers to disclose list prices for medications in television advertisements (*Merck v. HHS*, No. 19-5222 (D.C. Cir. June 16, 2020).

- Keep an eye on Medicare and Medicaid initiatives to reduce drug costs or change payment methods. These changes could affect the entire marketplace for specific medications. Medicare's recently announced Part D Senior Savings Model will examine the effects of reducing monthly insulin costs to $35 for participants in the five-year program. In addition, proposed changes to

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Medicaid's best-price requirements would encourage states to move toward value-based instead of volume-based reimbursement for prescription drugs provided to Medicaid beneficiaries.

Monitor implementation of the Trump administration's safe importation plan for prescription drugs.

- Track FDA activities and states' efforts to set up protocols to import certain medications from Canada that meet the health, safety and cost-saving standards to receive FDA certification. Also monitor the status of FDA's alternative pathway allowing drug manufacturers to reimport certain medications.
- Until FDA begins certifying importation programs, plans considering covering imported or reimported prescription drugs should evaluate current legal restrictions with counsel.

Non-Mercer resources

- *Am. Hosp. Ass'n v. Azar*, No. 1:19-cv-03619 (D.D.C., June 23, 2020); *motion for expedited appeal filed* (D.C. Cir. July 3, 2020)
- Proposed rule, Establishing minimum standards in Medicaid state drug utilization review and supporting value-based purchasing for drugs (CMS, June 19, 2020)
- *Merck v. HHS*, No. 19-5222 (D.C. Cir. June 16, 2020)
- Complaint in *Connecticut v. Sandoz*, No. 3:20-cv-00802 (D. Conn. June 10, 2020)
- Final rule, HHS notice of benefit and payment parameters for 2021 (Federal Register, May 14, 2020)
- Fact sheet, Medicare Part D senior savings model (CMS, March 11, 2020)
- Draft guidance, Importation of certain FDA-approved human prescription drugs, including biological products (FDA, Dec. 30, 2019)
- Proposed rule, Importation of prescription drugs (Federal Register, Dec. 23, 2019)
- Proposed rule, Transparency in coverage (Federal Register, Nov. 27, 2019)
- Final rule, Price transparency requirements for hospitals to make standard charges public (Federal Register, Nov. 27, 2019)
- Unlocking market access for gene therapies in the United States (McKinsey & Co., Aug. 22, 2019)
- Safe importation action plan (FDA, July 31, 2019)
- American patients first (HHS, May 11, 2018)

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- *Rutledge v. Pharm. Care Mgmt. Ass'n,* 891 F.3d 1109 (2018); *cert. granted,* No. 18-540 (U.S. Jan. 10, 2020)

Mercer Law & Policy resources

- 2021 ACA out-of-pocket maximums, ESR penalties, other changes ahead (June 3, 2020)
- Prescription drug importation gets renewed focus (Feb. 21, 2020)
- Roundup of selected state health developments, fourth-quarter 2019 (Jan. 21, 2020)

Other Mercer resources

- Pharmacy innovation & consulting
- Tackling specialty drug cost growth, one step at a time (Aug. 1, 2019)
- Employers weigh in on drug rebates (April 11, 2019)
- PBM chiefs spar with lawmakers over drug pricing (April 11, 2019)
- Big change ahead for Medicare — and employers will feel it too (Nov. 8, 2018)

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6

Transparency for group health plans, insurers and hospitals

Action

Review the final transparency regulation for hospitals, as well as the proposed rule for group health plans and insurers. Work with plan experts to review prices — including negotiated rates — that hospitals will have to make publicly available in 2021 under the final transparency rule. Prepare to comply with the transparency rule for group health plans and insurers that will probably take effect sometime in 2022. Watch for litigation that may delay or invalidate these rules.

Specific steps

Review the final hospital transparency rule to understand what rates hospitals must disclose in 2021, and work with plan experts to understand the data once released.

- **Explore new opportunities to negotiate or directly contract rates with individual hospitals or hospital systems if a particular plan currently pays higher rates than what other entities pay.** The final hospital transparency rule should provide unprecedented insights into the rates that participants and plans pay for medical services and items like prescription drugs at hospitals. Providers and PBMs generally have treated negotiated rates as proprietary information inaccessible to plan sponsors. The transparency rules could infuse more competition into the healthcare marketplace, allowing plan sponsors to negotiate better rates while giving participants upfront estimates of medical expenses to compare different providers.

- **Examine how newly disclosed information might help plan participants.** The final hospital transparency rule requires:

  - **Consumer-friendly disclosure.** Hospitals must provide payer-specific negotiated charges, plus discounted cash prices, and deidentified minimum and maximum negotiated charges — the lowest and highest negotiated average price at the hospital — for 300 shoppable services. This information must be displayed and packaged in a "consumer-friendly" manner (which can be met by using a price-estimator tool). Of the 300 shoppable services, CMS will select 70, and the hospital will choose the remainder.

  - **Publicly available, machine-readable files.** Each hospital must make available to the public machine-readable files that contain gross charges, payer-specific negotiated charges,

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discounted cash prices, and deidentified minimum and maximum negotiated charges for each item and service the hospital provides. The payer-specific negotiated charge is the charge for an item or service that a hospital has negotiated with an insurer or a TPA — or in some cases, directly with a plan or plan sponsor.

- **Penalty for noncompliance.** Hospitals that don't comply could incur a penalty of $300 per day.

Review the proposed transparency rule for group health plans and insurers, and prepare to comply — potentially beginning in 2022. Begin discussions with plan service providers to determine who will supply the required disclosures and how.

- **Examine how the transparency rule will affect your group health plan and its participants.** The proposed rule would require nongrandfathered group health plans, including self-funded plans and health insurance issuers, to take two key actions:
  - **Provide a self-service transparency tool.** This internet-based self-service tool would disclose personalized out-of-pocket costs for all covered healthcare items and services (with paper copies available on request). Participants could get an estimate of their cost-sharing liability for any in- or out of-network provider, allowing them to compare costs before receiving medical care. The tool would have to enable searching by billing code, descriptive terms, provider name and other relevant factors (such as geography). The tool would also have to track a participant's accruals toward any cumulative treatment limitations (like day or visit limits).
  - **Make machine-readable files publicly available.** Standardized machine-readable files, updated monthly, would contain the plan's negotiated rates for in-network providers and past allowed payments to out-of-network providers. Regulators intend this requirement to facilitate price comparison and consumer-oriented innovation in the healthcare market.
- **Review impact on potential MLR rebates.** To encourage consumers to shop for better prices, the rule would offer relief from MLR rebates if insured plans share cost savings with enrollees who choose less-expensive providers.
- **Avoid potential penalties for violations.** Group health plans failing to meet the new transparency rules could face steep penalties of $100/day per participant. However, many group health plan sponsors don't have access to all negotiated prices and can't provide the transparency disclosures without input from the plan's insurer or TPA. The proposed rule offers some relief to sponsors in this situation:
  - A proposed safe harbor would spare an employer with a fully insured group health plan from having to provide the transparency disclosures to participants, as long as a written agreement requires the insurer to do so. If the insurer fails to provide the required information, the insurer — not the group health plan — will face liability for the violation.

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- The proposed rules also provide relief for group health plans that act in good faith and with reasonable diligence to provide the disclosures, but make an error or omission or are unable to obtain complete or accurate information from another entity. Group health plans likewise would face no penalties if the website hosting the transparency tools and files is temporarily inaccessible.

Monitor litigation developments that could delay or invalidate these rules.

- A lower court has rejected legal challenges to the final hospital transparency rule (*Am. Hosp. Ass'n v. Azar*, No. 1:19-cv-03619 (D.D.C. June 23, 2020), but an appeal is pending. An appellate court could delay or invalidate the final rule, and the case may ultimately make its way to the US Supreme Court.
- Watch for possible legal challenges to the final transparency rule for group health plans and insurers.

Related resources

Non-Mercer resources

- *Am. Hosp. Ass'n v. Azar*, No. 1:19-cv-03619 (D.D.C., June 23, 2020); *motion for expedited appeal filed* (D.C. Cir. July 3, 2020)
- Presentation: Hospital price transparency rule (CMS, Dec. 3, 2019)
- Final transparency rule for hospitals (Federal Register, Nov. 27, 2019)
- Proposed transparency rule for group health plans and insurers (Federal Register, Nov. 27, 2019)

Mercer Law & Policy Resources

- Healthcare law and policy outlook for 2020 (Feb. 18, 2020)
- Mercer comments on proposed transparency in coverage rules (Jan. 31, 2020)
- Executive order targets healthcare price and quality transparency, and HSA/FSA changes (July 10, 2019)
- Top 10 compliance issues for 2020 health and fringe benefit planning (June 25, 2019)
- Mercer shares views with senators on controlling healthcare costs (March 6, 2019)

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Other Mercer resources

- Executive order on transparency, HSAs: What employers need to know (June 27, 2019)
- The new transparency regulations: Will consumers finally be able to shop for healthcare? (Nov. 21, 2019)

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7

Data privacy and security

Action

Assess how healthcare changes due to the COVID-19 pandemic will change data security priorities for group health plans. Look out for updated HIPAA standards, and focus on how they address emerging technologies. Prepare for data-sharing changes due to new interoperability regulations.

Specific steps

Evaluate the impact of the exponential rise in telehealth use during the pandemic. While some eased restrictions on the practice of telemedicine may end this year, many changes will remain in place.

- Evaluate privacy and security challenges to the use of telehealth, and how the plan or its vendors can address these concerns so this type of care can continue.
- Make sure TPAs and carriers have confirmed that their telehealth offerings and in-network providers ensure data security.
- Include language in business associate or data use agreements that requires vendors to meet evolving state telehealth laws.
- Re-evaluate current telehealth options in light of the changing array of offerings. Assess vendors' new telehealth solutions, and compare their privacy and security features against the telemedicine capabilities already available to employees through in-network providers.
- Update plan communications to increase awareness of telehealth offerings.

Focus on digital solutions for behavioral health that have become more widely used during the pandemic.

- Evaluate behavioral health technology vendors to determine whether their offerings' use and disclosure of electronic protected health information (ePHI) meet HIPAA standards and best practices.
- Assess whether federal or state laws place compliance obligations beyond HIPAA's standards on the use and disclosure of behavioral health information in general or substance use disorder records in particular.

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— Federal confidentiality rules for substance use disorder records (42 CFR Part 2) might place additional restrictions on a group health plan's access to and use of this information. Look for updated regulations by March 2021 to align these federal confidentiality standards with HIPAA, as required by the CARES Act.

— States may also have special rules on mental telehealth services that vendors and/or insured plans must meet.

Ensure employees know how any vendor uses or discloses their data, even when HIPAA doesn't apply. Consider obtaining employee consent to the information use or disclosure. This may be especially important for employers using new tracking and screening technologies as part of a pandemic return-to-work program.

- Keep in mind that HIPAA applies to group health plans, not employers. For example, an employer might have a return-to-work program open to all employees and not linked in any way to a group health plan. The employer might contract with a health technology company that uses a mobile app to track certain employee information as part of the program. If this arrangement is not a group health plan, HIPAA won't apply, but other federal or state laws will.

Stay informed about new or revised HIPAA guidance that may require updating or changing privacy and security policies or procedures — either temporarily due to the pandemic or permanently to keep up with new technologies. Evaluate how the guidance affects the plan, its sponsor, and existing or planned vendor initiatives.

- Watch for HHS guidance by late September on PHI disclosure during the COVID-19 public health emergency, as required by the CARE Act. To date, HHS's Office of Civil Rights (OCR) has issued some guidance that mostly affects healthcare providers. Additional guidance may address plan issues.

- Keep in mind that HIPAA obligations on group health plans' use and disclosure of PHI have not changed during the pandemic. Waivers of certain HIPAA rules due to COVID-19 apply mainly to providers, not plans. Employers sponsoring health plans still need to abide by HIPAA rules limiting PHI disclosure to the minimum necessary information and setting conditions for PHI disclosure to the public, family members and public health authorities.

- Look for a revised HIPAA notice of privacy practices by March 2021. The CARES Act requires the notice to include details on patients' rights and substance use disorder information protected under 42 CFR Part 2.

- Expect more urgent efforts to modernize the 20-year-old HIPAA regulations. Updates to HIPAA regulations have been discussed for some time, and HHS's latest regulatory agenda called for issuing a proposed rule by last month. The expanded use of telehealth and the final federal interoperability rules (discussed in next action step) will likely increase the pressure to move updated HIPAA rules forward in 2021.

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Monitor developments that involve data interoperability — the ability of plans, providers and patients to exchange data seamlessly in a uniform format.

- Review the final interoperability rules for health IT developers and healthcare payers and providers. Beginning July 2021, all Medicare Advantage, Medicaid managed care and public exchange plans must make claims and clinical data available on request through an open application programing interface (API). Separate rules prevent providers and other entities from blocking access to certain patient information. This will allow patients to use third-party software to access their data and provide these records to others. Although the rules don't place any compliance obligations on group health plans, easing participants' access to their own clinical and claims data should help them better coordinate care and evaluate costs.

- Monitor how these rules affect the private sector. While designed to ease data exchange, the interoperability rules also facilitate transparency initiatives to give participants better information about provider networks, formularies, claims and pricing. The API that plan participants use to access their claims and clinical information may or may not be connected to group health plan benefits.

- Assess vendors' new offerings that use APIs. More TPAs and insurers will offer health plans new apps that may require additional entities to access participant data.

- Consider the pros and cons — including privacy and security implications — of maintaining an API for data used by the plan and its TPA. Evaluate these offerings for gaps in privacy and security protections, and assess associated risks under state and federal law. HIPAA might not regulate these apps, but the Federal Trade Commission (FTC) enforces some privacy protections for mobile health apps and similar technology tools that use personal health information.

- Keep up with legislation in Congress to improve consumer protections in the rapidly evolving area of interoperability.

Related resources

Non-Mercer resources

- Final rule, Confidentiality of substance use disorder patient records (HHS, July 15, 2020)

- COVID-19: Substance use disorder, privacy and the CARES Act (Health Affairs blog, June 8, 2020)

- Final rule, Interoperability and patient access (CMS, May 1, 2020)

- Final rule, Interoperability, information blocking and the ONC health IT certification program (HHS, May 1, 2020)

- Pub. L. No. 116-136, the CARES Act (Congress, March 27, 2020)

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- FAQ 3009, Does a HIPAA covered entity that fulfills an individual's request to transmit ePHI to an application or other software bear liability for the app's use or disclosure of that information? (HHS, May 9, 2019)
- FAQ 3012, Can a covered entity refuse to disclose ePHI to an app chosen by an individual because of concerns about how the app will use or disclose the ePHI? (HHS, May 9, 2019)
- FAQ 3013, Does HIPAA require a covered entity or its EHR system developer to enter into a business associate agreement with an app designated by the individual in order to transmit ePHI to the app? (HHS, April 18, 2019)
- Request for information on modifying HIPAA rules to improve coordinated care (Federal Register, Dec. 14, 2018)
- Sharing consumer health information? (HHS, June 16, 2017)
- Final HIPAA privacy, security, enforcement and breach notification rules (Federal Register, Jan. 25, 2013)
- Privacy and security resources for tech tools (FTC)

Mercer Law & Policy resources

- COVID-19 raises HIPAA privacy, security issues (April 6, 2020)
- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)
- California's data privacy law appears not to reach HIPAA-covered group health plans, but other impacts unclear (April 8, 2019)

Other Mercer resources

- Your telehealth pandemic toolbox (April 23, 2020)
- Sign me up, or not for me? Workforce digital health personas (Feb. 27, 2020)

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8

HSA, HRA and FSA developments

Action

For 2021, ensure administrative practices comply with optional or required COVID-19 relief. Update HDHPs, HSAs, health FSAs and excepted-benefit HRAs for indexed dollar limits. Consider adding newly HSA-eligible preventive services to HDHP coverage and allowing health accounts to reimburse OTC drug costs without a prescription and, if permissible, DPCA fees. Identify pre- or no-deductible health benefits, programs or point solutions that could jeopardize HSA eligibility, and determine whether to make changes. Consider whether to offer one of the new types of HRAs — an individual-coverage HRA or an excepted-benefit HRA. Update systems, plan documents, SPDs, SBCs and other employee materials as needed. Monitor pending COVID-19 relief legislation that could enhance HSAs or provide greater FSA flexibility for 2021.

Specific steps

Revisit COVID-19 relief guidance, and confirm compliance with any relief extending into 2021 and beyond. Prepare to discontinue any plan practices adopted for temporary relief available only for 2020 (for now), such as the eased rules for making midyear election changes for health coverage, health FSAs and DCAPs and the special grace period for health FSAs and DCAPs. Timely adopt plan amendments for any COVID-19 relief implemented.

- **Permanent relief for HSA-qualifying HDHPs permits pre- or no-deductible coverage of COVID-19 testing and treatment.** HSA-qualifying HDHPs may cover COVID-19 testing and treatment before individuals have met their deductibles, without jeopardizing eligibility to make or receive HSA contributions. HDHPs must cover COVID-19 *testing* without cost sharing, but HDHP coverage for COVID-19 *treatment* free of cost sharing is optional, though future legislation could require this coverage (see earlier discussion of required COVID-19 testing coverage). Although IRS Notice 2020-15 says this guidance comes in response to COVID-19, the relief does not have an expiration date and will remain in effect until revised or rescinded.

- **Temporary COVID-19 relief for HSAs and HDHPs eases rules for telehealth and other remote care.** HSA-qualifying HDHPs can — but are not required to — cover *all* (not just COVID-19-related) telehealth and remote care services before individuals have met their deductible, without jeopardizing eligibility to make or receive HSA contributions. Individuals also may receive all telehealth or remote care services free of cost sharing, without jeopardizing HSA eligibility. This relief covers even stand-alone telehealth or other remote care programs not integrated with the HDHP (see earlier discussion of this relief). These provisions apply only for plan years beginning

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on/before Dec. 31, 2021 (e.g., the 2020 and 2021 calendar plan years). Monitor whether future legislation or regulatory guidance make this relief permanent.

- **COVID-19 relief for health FSAs and HRAs extending the claims run-out period.** If the normal deadline to submit health FSA or HRA claims incurred during the prior plan year falls after March 1, 2020, suspend counting down any time remaining in the claims run-out period until the COVID-19 "outbreak period" has ended. For this purpose, the outbreak period ends 60 days after the announced end of the COVID-19 national emergency or the date announced in future agency guidance. If the outbreak period ends on different dates in different regions, the agencies will issue additional guidance. The extended deadline does not apply to dependent care FSAs because they are not subject to ERISA.
  - Watch for the announced end of the COVID-19 national emergency and agency guidance to determine when the claims run-out period ends. Depending on the health FSA or HRA plan year and when the outbreak period ends, a claims run-out period could extend into 2021. Here's an example of how this applies to a July 1 noncalendar-year health FSA:

    Example. Assume the COVID-19 national emergency ends Aug. 31, so the outbreak period ends Oct. 30. Peter elected to contribute to a health FSA that has a 92-day run-out period ending Sept. 30, 2020, to submit claims from the plan year that ended June 30, 2020. Due to the COVID-19 relief, Peter now has 92 days after the end of the outbreak period to submit claims incurred during the previous plan year. This means Peter has until Jan. 30, 2021, to use or lose any of the balance remaining in his health FSA as of June 30, 2020.

  - Confirm the FSA administrator has extended the claims run-out deadline and communicated it to participants.

Revise HDHP and HSA limits for 2021 amounts issued in Rev. Proc. 2020-32:

- **Annual HSA contribution limits.** The 2021 contribution limits will increase to $3,600 (self-only) and $7,200 (family) — up from $3,550 and $7,100 in 2020. The annual catch-up contribution for individuals ages 55 and older remains $1,000 (not indexed).
- **HDHP in-network out-of-pocket (OOP) limits.** The OOP limits will increase to $7,000 (self-only) and $14,000 (family) in 2021, up from $6,900 and $13,800 in 2020. HDHPs can set lower — but not higher — caps on in-network OOP expenses. Keep in mind that ACA's higher 2021 OOP limits ($8,550 / $17,100) for nongrandfathered group health plans don't apply to HDHPs, except when required to embed an individual in-network OOP limit into family HDHP coverage.
- **HDHP minimum annual deductible.** The minimum deductibles for 2021 will remain $1,400 (self-only) and $2,800 (family), unchanged from 2020.

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Consider updating HDHP design for recent IRS guidance broadening the types of pre- or no-deductible preventive services allowed. Screen for other pre- or no-deductible health benefits that could jeopardize HSA eligibility.

- **Determine whether to add pre- or no deductible HDHP coverage of newly classified HSA-eligible preventive services, items and prescription drugs for certain chronic conditions.** IRS Notice 2019-45 identifies 14 preventive services, items and prescription drugs to treat certain chronic conditions that HSA-qualifying HDHPs can — but are not required to — provide on a pre- or no-deductible basis, without jeopardizing an individual's eligibility to make or receive HSA contributions. Whether an HDHP reimburses these expenses is a matter of plan design.

- **Identify pre- or no-deductible health-related benefits, programs or point solutions that could jeopardize an individual's eligibility to make or receive HSA contributions, and confirm strategy.** Look broadly at telehealth services (which are subject to COVID-19 temporary relief), on-site medical clinics, wellness programs, expert medical-opinion services, executive supplemental health benefits, international and travel health plans, coupons for prescription drugs or manufacturer discounts (see earlier discussion), or specialized care or disease-management programs (e.g., diabetes control, genetic tests, sleep apnea treatment, maternity support, fertility and infertility services, and behavioral health support). Keep in mind that long-standing IRS guidance permits predeductible preventive care and health benefits that don't provide significant medical care, such as some on-site clinics, disease-management programs, wellness plans or EAPs.

Decide whether to allow health accounts to reimburse OTC drugs without a prescription and, if permissible, DPCA fees. Analyze impact of DPCAs on HSA eligibility.

- **OTC drugs/medications and menstrual care products reimbursable.** The CARES Act eliminated the ACA's ban on pretax reimbursement of the costs for OTC drugs not prescribed by a physician. As a result, health FSAs, HRAs and HSAs may now reimburse the costs for OTC medicines and drugs, even without a physician's prescription. The CARES Act also allows these health accounts to treat menstrual care products as reimbursable medical expenses. Whether a health FSA or an HRA reimburses these expenses is a matter of plan design.

- **Reimbursement of DPCA fees and DPCA impact on HSA eligibility.** A DPCA is a contract between an individual and one or more primary care physicians under which the physician(s) agree to provide medical care for a fixed annual or periodic fee without billing a third party. According to proposed regulations, the fees paid for a DPCA that provides primary care services and items, such as physical examinations, vaccinations, urgent care, laboratory testing, and the diagnosis and treatment of sickness or injuries are payments for "medical insurance." In more limited circumstances, DPCA fees paid solely for providing specified treatments of an identified condition or an annual physical examination are payments for "medical care."

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- **HRA reimbursement always OK.** Proposed regulations allow HRAs to reimburse all types of DPCA fees, regardless of whether they are for medical insurance or medical care. Whether an HRA reimburses these expenses is a matter of plan design.
- **Health FSAs reimbursement limited to medical care.** Health FSAs cannot reimburse medical insurance premiums, so they likely could reimburse only DPCA fees for medical care. Additional IRS guidance on this issue would be helpful. Whether a health FSA reimburses these expenses is a matter of plan design.
- **HSA reimbursement of medical care OK; medical insurance maybe.** HSAs generally cannot reimburse medical insurance premiums (subject to certain statutory exceptions), so HSAs likely could reimburse only DPCA fees for medical care. Additional IRS guidance on this issue would be helpful. However, HSAs probably could reimburse DPCA fees that qualify as medical insurance premiums if the individual covered by the DPCA is receiving unemployment compensation or the HSA holder is age 65 or older. Finally, if a DPCA is considered a health plan or medical insurance, an individual covered by the DPCA would be ineligible to make or receive HSA contributions. (Note that pending legislation and proposals would allow HSA-eligible individuals covered by DPCAs to remain eligible to make or receive HSA contributions.)

Decide whether to increase the health FSA carryover amount to $550 and index this limit in future years, as provided by IRS Notice 2020-33.

- The maximum health FSA carryover amount has increased to 20% of the limit on employee pretax contributions for a plan year. At a plan sponsor's discretion, carryovers from the 2020 plan year to the 2021 plan year can — but are not required to — increase from $500 to $550 (20% of the 2020 contribution limit of $2,750). Plan sponsors that decide to increase the carryover amount must adopt a plan amendment by Dec. 31, 2021.

Review the final regulations creating individual-coverage HRAs and excepted-benefit HRAs, and decide whether to offer either option. Watch for the final version of proposed regulations detailing how individual-coverage HRAs interact with the ACA's ESR requirements and the nondiscrimination rules for self-funded group health plans under Section 105(h) of the tax code. Evaluate existing retiree-only arrangements that reimburse individual health insurance premiums to see if ERISA applies.

- **Individual-coverage HRA.** This type of HRA can reimburse active (and former) employees and their dependents for all types of medical care (as defined in Internal Revenue Code (IRC) § 213(d)), including Medicare and individual health insurance premiums if certain criteria are met. Notably, participants (and any covered dependents) must be enrolled in Medicare or individual health insurance that covers more than excepted benefits, and employees in the same "class" generally can't be offered the choice of enrolling in an individual-coverage HRA or a traditional group health plan. Draft 2020 IRS Form 1095-C has eight new line 14 codes to accommodate ESR and premium tax credit reporting for employers offering individual-coverage HRAs.

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- **Excepted-benefit HRA.** This type of stand-alone HRA can reimburse most qualified medical expenses (as defined in IRC § 213(d)), with new contributions allowed up to an annual dollar limit ($1,800 in 2020, indexed for inflation thereafter). Carryovers are permitted and don't count against the annual limit. The HRA will qualify as a HIPAA-excepted benefit (and thus be exempt from many ERISA/ACA mandates) if certain criteria are met. Notably, participants offered an excepted-benefit HRA must have the option to enroll in traditional group health plan coverage, although actual enrollment isn't required.

- **ERISA safe harbor.** The rules create a safe harbor from ERISA's requirements for the individual health insurance policies reimbursed by HRAs, other account-based plans and cafeteria plans. Notably, this extends to current arrangements, including retiree-only HRAs. To meet the safe harbor, sponsors must satisfy several conditions.

Update systems, plan documents, SPDs, SBCs and other employee materials as needed.

- Work with TPAs, payroll staff and other vendors to coordinate necessary updates and adopt timely plan amendments.

Monitor legislative proposals that would enhance HSAs or provide greater FSA flexibility.

- **HSA enhancement.** Some HSA enhancements are in the mix as Congress considers additional COVID-19 relief legislation. HSA reforms that may have a chance of advancing include a proposal to make permanent the CARES Act relief allowing pre- or no-deductible coverage of telehealth and remote care services. Other proposals would allow pre- or no-deductible coverage of more robust services (including primary care and management of chronic conditions) at on-site medical clinics, and add screening and treatment of infectious diseases to the list of HSA-eligible preventive care.

- **Greater FSA flexibility.** House-passed COVID-19 relief legislation — the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act (HR 6800) — contains a number of provisions that would give more flexibility to cafeteria plans, health FSAs and dependent care FSAs during the pandemic. Whether any of these provisions will land in a final bill is unclear, but here are some key provisions to monitor for 2021:

  - Health FSAs could permit participants to carry over up to $2,750 in unused benefits or contributions from a plan year ending in 2020 to the next plan year.

  - Dependent care FSAs could permit participants to carry over up to $5,000 (or $2,500 if married and filing separately) in unused benefits or contributions from a plan year ending in 2020 to the next plan year.

  - Both health and dependent care FSAs could extend the grace period for incurring expenses against unused funds from the plan year ending in 2020 from a maximum of 2-1/2 months to 12 months. Recent IRS guidance (Notice 2020-29) expanding the FSA grace period is more limited and applies only until the end of 2020.

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Related resources

Non-Mercer resources

- Proposed rule, Certain medical care arrangements (Federal Register, June 10, 2020)
- Rev. Proc. 2020-32, 2021 inflation-adjusted HSA and HDHP amounts (IRS, May 20, 2020)
- HR 6800, the HEROES Act (May 12, 2020)
- Section-by-section summary of the HEROES Act (May 12, 2020)
- Notice 2020-33, Modification of carryover rule for health FSAs and clarification of premium reimbursements by individual-coverage HRAs (IRS, May 12, 2020)
- Notice 2020-29, COVID-19 relief for cafeteria plans and HDHPs (IRS, May 12, 2020)
- Joint DOL and IRS notice, Extension of certain timeframes for employee benefit plans, participants and beneficiaries affected by the COVID-19 outbreak (Federal Register, May 4, 2020)
- Pub. L. No. 116-136, the CARES Act (Congress, March 27, 2020)
- Notice 2020-15, HDHPs and expenses related to COVID-19 (IRS, March 11, 2020)
- Proposed rule, Application of the ESR provisions and certain nondiscrimination rules to HRAs and other account-based group health plans integrated with Individual health insurance coverage or Medicare (Federal Register, Sept. 30, 2019)
- Notice 2019-45, Additional preventive care benefits permitted for an HDHP under § 223 (IRS, July 17, 2019)
- Final rule, HRAs and other account-based group health plans (Federal Register, June 20, 2019)
- FAQs on individual coverage and excepted-benefit HRAs (DOL, June 13, 2019)
- Publication 969, HSAs and other tax-favored health plans (IRS, annually updated)

Mercer Law & Policy resources

- 2021 ACA out-of-pocket maximums, ESR penalties, other changes ahead (June 3, 2020)
- IRS offers relief to cafeteria plans, HDHPs, individual-coverage HRAs (May 28, 2020)
- IRS, DOL ease deadlines for health, other benefit plans and participants (May 27, 2020)
- House aid bill aims to boost health benefits, COVID-19 leave, retention (May 21, 2020)

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- 2021 health savings account, high-deductible health plan figures set (May 20, 2020)
- Keeping track of COVID-19 laws affecting employee benefits, jobs (May 4, 2020)
- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)
- COVID-19 spurs IRS relief for HDHPs, state insurance guidance (March 18, 2020)
- Virus aid legislation includes cost-sharing curbs, new leave rights (March 18, 2020)
- Healthcare law and policy outlook for 2020 (Feb. 18, 2020)
- 2020 quick benefit facts (Jan. 27, 2020)
- Health savings account reforms pass key House panel (Nov. 1, 2019)
- IRS outlines how individual-coverage HRAs can meet ACA employer mandate (Oct. 29, 2019)
- IRS expands predeductible preventive care for HSA-qualifying health plans (July 23, 2019)
- Executive order targets healthcare price and quality transparency, and HSA/FSA changes (July 10, 2019)
- Final rules ease restrictions on health reimbursement arrangements (June 14, 2019)

Other Mercer resources

- Stay informed on the coronavirus (regularly updated)
- Consumer-directed health plans
- US Health News: Consumerism
- Congress nears decisions on health policy in virus relief bill (July 16, 2020)
- Use the telemed safe harbor while it lasts (July 6, 2020)
- Direct primary care gains ground as employer strategy (July 9, 2020)
- Direct primary care as a strategy to manage cost (Aug. 1, 2019)
- Executive order on transparency, HSAs: What employers need to know (June 27, 2019)
- Why consider point solutions? (And what are they, anyhow?) (April 26, 2018)

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9

Preventive services

Action

Confirm nongrandfathered group health plans offer all ACA-required in-network preventive services without cost sharing. Modify 2021 benefits for the latest ACA guidance and any new or updated USPSTF, HRSA and ACIP recommendations, including coverage of "qualifying coronavirus preventive services" (when available). Coverage generally must conform for plan years that begin on or after one year from the last day of the month in which the recommendation was issued or updated. However, plans must cover a COVID-19 vaccine or other preventive item or service within 15 days after it receives an A or a B recommendation from the USPSTF or is recommended by the CDC's ACIP.

Specific steps

Monitor development of COVID-19 preventive services or vaccines.

- Nongrandfathered health plans must provide coverage without any cost sharing within 15 days after a COVID-19 vaccine or other preventive item or service receives a USPSTF A or B recommendation or an ACIP recommendation.
- Grandfathered plans should consider covering the vaccine free of cost sharing as well.
- Plans may also want to cover the vaccine free of cost sharing as soon as it has FDA approval and becomes available to participants, even if this happens before the USPSTF or ACIP issues a formal recommendation.

Add or update no-cost in-network coverage of preventive services with a USPSTF A or B recommendation issued in 2019 and effective Jan. 1, 2021, for calendar-year plans. For noncalendar-year plans, the effective date could be plan year beginning in 2020 or 2021, depending on plan year's start date relative to the date USPSTF issued the recommendation.

- **Ocular prophylaxis medication to prevent gonococcal ophthalmia neonatorum for all newborns.** Provide prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum. This updated recommendation reaffirms one from 2011. (Issued January 2019)
- **Perinatal depression counseling for pregnant and postpartum persons.** Provide or refer pregnant and postpartum persons at increased risk of perinatal depression to counseling interventions. This is a new USPSTF recommendation. (Issued February 2019)

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- **Pre-exposure prophylaxis (PrEP) medication for the prevention of human immunodeficiency virus (HIV) infection.** Offer PrEP with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. This is a new USPSTF recommendation. (Issued June 2019)
- **Human immunodeficiency virus (HIV) infection screening for adolescents and adults ages 15–65, younger adolescents and older adults at increased risk, and all pregnant persons.** Screen for HIV infection in (i) adolescents and adults ages 15–65, (ii) younger adolescents and older adults who are at increased risk of infection, and (iii) all pregnant persons, including anyone in labor or at delivery whose HIV status is unknown. This updated recommendation is consistent with one from 2013. (Issued June 2019)
- **Hepatitis B virus (HBV) infection screening in pregnant women.** Screen for HBV infection in pregnant women at their first prenatal visit. This updated recommendation reaffirms one from 2009. (Issued July 2019)
- **BRCA-related cancer risk assessment and genetic counseling/testing for at-risk women.** Use appropriate brief familial risk assessment tool to screen women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with BRCA1/2 gene mutations. For women with a positive result on the risk assessment tool, provide genetic counseling and, if indicated after counseling, genetic testing. This update to a 2013 recommendation revises the population eligible for screening to add women who have completed treatment for breast, ovarian, tubal or peritoneal cancer diagnosis and are considered cancer-free. The update also more explicitly includes ancestry associated with BRCA1/2 mutations (i.e., founder mutations) as a risk factor. (Issued August 2019)
- **Breast cancer medication to reduce risk for women ages 35 or older.** Offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene or aromatase inhibitors, to women ages 35 or older at increased risk for breast cancer and low risk for adverse medication effects. This updated recommendation is consistent with one from 2013. (Issued September 2019)
- **Asymptomatic bacteriuria screening for pregnant persons.** Screen pregnant persons with a urine culture for asymptomatic bacteriuria. This updated recommendation is consistent with one from 2008. (Issued September 2019)
- **Abdominal aortic aneurysm (AAA) screening with ultrasonography in men ages 65–75 who have ever smoked**. Perform one-time screening for AAA with ultrasonography in men ages 65-75 who have a history of smoking. This updated recommendation is consistent one from 2014. (Issued December 2019)

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Add or update in-network coverage without cost sharing for all types of ACA-mandated preventive-service recommendations issued in 2020.

- **Hepatitis C virus (HCV) infection screening for adults ages 18–79.** Screen for HCV infection in adults ages 18–79. This recommendation replaces the 2013 version by expanding the population who should be screened. The USPSTF previously recommended screening of persons at high risk for infection and one-time screening of adults born between 1945 and 1965. (Issued March 2020)
  - Conform coverage for noncalendar-year plans starting on or after April 1 in 2021; on Jan. 1, 2022, for calendar-year plans; and on the first day of the 2022 plan year for noncalendar-year plans beginning before March 31.
- **Prevention and cessation of tobacco use counseling for in children and adolescents younger than ages 18.** Provide interventions, including education or brief counseling, to prevent use of tobacco products, including e-cigarettes, among school-age children and adolescents. This updated recommendation is consistent with one from 2013 but adds e-cigarettes as a tobacco product. (Issued April 2020)
  - Conform coverage for noncalendar-year plans starting on or after May 1 in 2021; by Jan. 1, 2022, for calendar-year plans; and by the first day of the 2022 plan year for noncalendar-year plans beginning before April 30.
- **Unhealthy drug use screening for adults ages 18 or older.** Screen by asking questions about unhealthy drug use (without testing biological specimens) in adults age 18 years or older. Screen only when able to offer or refer to services for accurate diagnosis, effective treatment and appropriate care. This replaces a 2008 USPSTF recommendation, which found insufficient evidence at that time to assess the balance of benefits and harms of screening for illicit drug use in adolescents and adults, including those who were pregnant or postpartum. (Issued June 2020)
  - Conform coverage for noncalendar-year plans starting on or after July 1 in 2021; by Jan. 1, 2022, for calendar-year plans; and by the first day of the 2022 plan year for noncalendar-year plans beginning before June 30.
- **Any additional preventive services recommended during 2020.** If any additional preventive-service recommendations are issued in 2020, ensure noncalendar-year plans comply by the applicable 2021 or 2022 effective date and calendar-year plans comply by Jan. 1, 2022.

Maintain coverage of ACA-mandated women's contraceptives, unless the employer has religious or moral objections to contraceptives.

- Continue to cover all FDA-approved women's contraceptives without cost sharing, unless declining or revoking this coverage due to moral or religious objections.

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- If asserting a religious or moral objection, decide whether to voluntarily adopt an accommodation — or revoke an existing accommodation — allowing participants to obtain women's contraceptive coverage, if available, directly from the insurer or TPA.
  - Nongovernmental employers with sincerely held religious or moral objections may exclude coverage of some or all FDA-approved women's contraceptives, under 2018 final regulations recently upheld by the Supreme Court (*Little Sisters of the Poor v. Pennsylvania*, No. 19–431 (U.S. July 8, 2020)). However, ongoing litigation on this issue and the potential for a new administration to amend these rules in 2021 leave some uncertainty about the future of these exemptions.
  - The religious exemption is available to all types of nongovernmental employers, including nonprofit entities, privately held and publicly traded for-profit corporations, churches, and institutions of higher education that arrange student health insurance coverage.
  - The moral exemption is available to the same entities described above, with the exception of publicly traded corporations.

Update official plan documents, SPDs, SBCs and other materials as needed.

Related resources

Non-Mercer resources

- *Little Sisters of the Poor v. Pennsylvania*, No. 19–431 (U.S. July 8, 2020)
- Final rule, Moral exemptions and accommodations for coverage of certain preventive services under the ACA (Federal Register, Nov. 15, 2018)
- Final rule, Religious exemptions and accommodations for coverage of certain preventive services under the ACA (Federal Register, Nov. 15, 2018)
- Final rule, Coverage of certain preventive services under the ACA (Federal Register, July 14, 2015)
- USPSTF A and B recommendations (USPSTF)
- Women's preventive services guidelines (HRSA)
- ACIP vaccine recommendations and guidelines (ACIP)

Mercer Law & Policy resources

- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)

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Other Mercer resources

- Why do I keep getting billed for preventive health services? (Oct. 25, 2018)
- Contraceptive coverage: Good for women, good for business (July 12, 2018)
- Trump administration rolls back ACA contraceptive mandate (Oct. 9, 2017)

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10

Other ongoing ACA concerns

Action

Review 2021 group health plan coverage and eligibility terms in light of ESR strategy, ESR and MEC reporting duties, and ACA benefit mandates. Determine whether the proposed grandfathered health plan rule, if/when finalized, will help preserve grandfathered status (if applicable). Prepare updated SBCs for 2021 plan open enrollment. Continue to calculate and pay the PCORI fee for self-funded health plans, prepare for MLR rebates, and confirm the absence of a HIT premium bump for fully insured health plans. Review potential sex discrimination concerns in benefit eligibility and other plan terms. Monitor ongoing litigation challenging the ACA. Revisit any changes planned or implemented to mitigate the once-impending but now-repealed Cadillac tax.

Specific steps

Review planned 2021 benefits against ESR standards, including MEC for ACA full-time employees and the minimum value and affordability of health coverage.

- Evaluate required employee contributions for the lowest-cost, self-only option against the 2021 affordability percentage and the employer affordability safe harbors. As of the publication date of this GRIST, IRS has not issued the 2021 ESR affordability percentage, but Mercer projects the percentage will increase slightly from the current 9.78% to 9.82% or 9.83% for 2021.
  - When the 2021 ESR affordability percentage is issued, calendar-year plans using federal poverty-line safe harbor should calculate the maximum monthly 2021 employee contribution.
- Check the IRS website for updated Q&As (#55) giving the 2021 ESR assessment amounts. Mercer projects the 2021 ESR assessments will be:
  - $2,700 per ACA full-time employee for employers that do not offer MEC to at least 95% of ACA full-time employees (and their dependents), and at least one of those employees receive federally subsidized coverage through a public exchange
  - $4,060 per ACA full-time employee receiving federally subsidized coverage through a public exchange because the employee wasn't among the 95% of ACA full-time employees offered employer MEC or was offered employer MEC that was unaffordable or less than minimum value

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Consider benefit-eligibility terms or alternative health benefit options for part-time or former employees who don't trigger ESR assessments when not offered MEC.

- Weigh how the need for employer coverage may change. Demand could increase due to the COVID-19 pandemic and the growing number of states with individual-coverage mandates. So far, California, Massachusetts, New Jersey, Rhode Island, Vermont and Washington, DC, have enacted these mandates.

- Consider offering a stand-alone telehealth program, expanded EAP or on-site clinic to employees ineligible for the traditional group health plan. Agency COVID-19 guidance temporarily permits an excepted-benefit EAP to cover COVID-19 diagnostic and testing services and allows certain stand-alone telehealth programs to avoid many ACA market reforms. Employer on-site medical clinics can offer expanded services and retain excepted-benefit status, without limitation tied to the COVID-19 emergencies. (For more information, see COVID-19 issues for health plans.)

Ensure adequacy of ESR recordkeeping and reporting.

- IRS continues to issue ESR assessments. The agency first began notifying employers in late 2017 about their potential liability for the 2015 calendar year (the first year the ESR mandate was in effect). IRS has actively collected assessments from applicable large employers every year since. In a December 2019 memorandum, the agency concluded that no statute of limitations applies to ESR assessments, suggesting assessment letters could come more than three years after the calendar year to which they apply.

- Check for reporting errors that can result in inaccurate ESR assessments. The Treasury Inspector General for Tax Administration (TIGTA) reports that employer reporting errors cause most adjustments to proposed ESR assessments. Some employers have made the same reporting error two years in a row. The most common mistake leading to a revised assessment involved reporting on Form 1094-C that the employer did not offer MEC to at least 95% of ACA full-time employees (and their dependents) when the employer actually did satisfy that threshold.

- Address any Forms 1094-C or 1095-C reporting deficiencies identified in an initial IRS assessment Letter 226-J, and correct prior-year reports as necessary. Confirm that recordkeeping suffices to respond to any future IRS assessment letters.

- Plan for 2020 reports due in 2021, and continue to collect information for 2021 reports due in 2022. Confirm the appropriate measurement method — lookback or monthly — is used to identify ACA full-time employees.

- If offering an individual-coverage HRA, draft 2020 IRS Form 1095-C has eight new line 14 codes to accommodate ESR and premium tax credit reporting.

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Review plan design for compliance with ACA benefit mandates.

- Continue to comply with ACA benefit mandates, such as waiting-period restrictions, the ban on lifetime and annual dollar limits for essential health benefits (EHBs), the required first-dollar coverage of specified preventive services, and the annual in-network OOPMs for EHBs.
- Monitor a proposed triagency rule (with accompanying FAQs) that would add an alternative measure of inflation, based on the HHS annually published premium adjustment percentage, to determine the maximum permissible increase in the fixed-dollar cost-sharing amounts that will not cause a plan to lose grandfathered status. The rule would also provide flexibility for HSA-qualifying HDHPs to make IRS required increases to deductibles without losing grandfathered status.

Confirm use of new SBC templates during open enrollment for 2021 plans.

- Use new models to prepare SBCs for the first day of open enrollment for the first plan year starting on or after Jan. 1, 2021. Updated materials include a SBC template, uniform glossary, sample completed SBC, instructions and guides for coverage example calculations — each in multiple languages. Updates to the coverage calculator may result in different values for coverage examples, even when the plan design has not changed. The new models replace 2017 versions.
  - Review updated instructional guides for specific instructions on how to account for HRAs, HSAs and other healthcare accounts, along with health plan features like wellness programs.

Review any proposed changes to selected state benchmark plans.

- If using a state benchmark plan to identify which covered benefits are — or are not — EHBs subject to in-network OOPMs and the ban on annual or lifetime dollar limits, review the selected benchmark for any changes applicable in 2021, and consider other states' updates (if any).

Continue to calculate and pay the PCORI fee for self-funded group health plans, including certain HRAs and retiree-only plans.

- The appropriations package (Pub. L. No. 116-94) enacted late last year extended the PCORI fee for another 10 years to plan years that end before Oct. 1, 2029. The fee funds research on the clinical effectiveness of various medical treatments and care options. Carriers are responsible for paying the fee for insured plans.
  - The fee due July 31, 2021, for noncalendar-year or short calendar-year plans ending in 2020 before Oct. 1 is $2.54 multiplied by the average number of lives covered under the plan.
  - The adjusted applicable fee per covered life due July 31, 2021, for 2020 calendar-year plans and noncalendar-year plans ending in 2020 on or after Oct. 1 will likely be announced this fall.

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If sponsoring a fully insured group health plan, prepare for continued MLR rebates, and the end of HIT increases to premiums.

- Expect 2019 MLR rebates (issued in 2020) in the small- and large-group market to be similar to 2018 amounts (issued in 2019), although rebates to individual policyholders likely will exceed last year's due to stabilization in the individual market. In addition, HHS has given insurers permission to issue estimated 2019 MLR rebates earlier than normal. The ACA requires these rebates if an insurer fails to spend a minimum percentage of premiums on healthcare claims and quality improvements.
  - Review plan documents for language addressing the handling of rebates, and follow those provisions accordingly. If plan documents are silent, consider an amendment to address rebates, refunds, plan distributions, etc. When the plan document is silent, the employer must determine how much of the rebate is plan assets that must be used to benefit participants.
  - Nonfederal government employers and church plans should consult HHS rules on the management of MLR rebates.
  - Once informed about a carrier's intent to issue a rebate, communicate with plan participants on how the rebate will be handled.
  - Because MLR rebates are based on a three-year average of financial data — e.g., 2016–2018 data for 2019 rebates — predicting the pandemic's effect on 2020 rebates payable in 2021 is difficult. On the one hand, the public health crisis has forced the cancellation of elective procedures and caused many individuals to delay or forgo care. On the other hand, the cost to insurers for covering COVID-19-related treatment is unknown. In addition, some carriers experiencing lower than expected utilization have issued premium holidays this year.
- Expect no more HIT adjustments to premiums charged by carriers. First effective in 2014 but suspended in 2017 and 2019, this annual ACA fee based on a health insurer's market share has factored into the premiums charged to fully insured employer group health plans. Effective Jan. 1, 2021, federal spending legislation enacted late last year has permanently repealed the HIT.
  - Fully insured employers in some states — including Colorado, Delaware and Maryland — may see the federal HIT replaced by a similar state tax approved under an ACA Section 1332 innovation waiver to help fund a state-based reinsurance program.

Review plan design for sex discrimination.

- Review benefit eligibility and other plan terms for sex discrimination in light of the Supreme Court's decision in *Bostock v. Clayton County, Ga.*, finding Title VII of the 1964 Civil Rights Act protects LGBTQ employees.

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  - Confirm benefits offered to opposite-sex spouses are also offered to same-sex spouses. If offering domestic partner coverage, confirm benefits are offered to both same-sex and opposite-sex domestic partners.
  - Review group health plan terms excluding or limiting coverage for gender dysphoria or related services for risk under Title VII and the MHPAEA.
  - Review the group health plan's provider network for adequate access to providers supportive of and knowledgeable about LGBTQ healthcare. Consider a provider directory identifying practitioners welcoming LGBTQ patients and/or with expertise in LGBTQ health issues.
  - Review gender assignments used in benefit administration, and consider options for more inclusive descriptors.
  - Review disability plan coverage for temporary disabilities due to gender-affirmation surgeries.
  - Employers with strong religious convictions should consult with legal counsel about the risk of discriminatory benefits and potential exemptions.
- For employers with federally funded healthcare plans or programs, monitor litigation related to revised final regulations for ACA Section 1557 nondiscrimination standards. The revised rules narrow the statute's application to employer group health plans receiving federal funding and remove the transgender protections outlined in the 2016 final regulations. The changes take effect Aug. 18, 2020, absent a court ruling enjoining the effective date or HHS action rescinding or revising the regulations.
  - Remember that Title VII nondiscrimination principles still apply, regardless of the status of the Section 1557 regulation.

Monitor ongoing litigation striking down the entire ACA and any congressional response.

- The Supreme Court later this year will hear arguments in two consolidated ACA cases (*California v. Texas,* 945 F.3d 355 (2019)*; cert. granted,* No. 19-840 (U.S. March 2, 2020), with an opinion expected in 2021. At issue is the constitutionality of the individual mandate after Congress reduced the penalty to zero. If the individual mandate is unconstitutional, the court is asked to decide whether the entire law is void or if just limited sections — including the ban on preexisting condition exclusions — are invalid in addition to the individual mandate. The decision will have implications for the ESR mandate and associated reporting, among other ACA requirements.

Revisit any benefit changes planned or implemented to minimize Cadillac tax exposure that are no longer needed because of the tax's repeal in late 2019.

- Consider whether to undo any strategies employed to avoid, reduce or delay the application of the 40% excise tax on high-cost employer-provided health coverage previously slated to begin in 2022.

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For example, some employers have been phasing in cost-shifting changes, such as increasing employee cost-sharing (e.g., via higher deductibles, copays or coinsurance); reducing covered benefits; or altering account-based plans. Revisit any plan changes — such as elimination of employee pretax HSA contributions — contemplated to mitigate exposure to this excise tax.

Related resources

Non-Mercer resources

- Section 1332 state innovation waivers (CMS)
- Information on EHB benchmark plans (CMS)
- Medical loss ratio (CMS)
- Affordable Care Act provision 9010 — health insurance providers fee (IRS, June 19, 2020)
- Patient-Centered Outcomes Research Institute fee (IRS, June 2, 2020)
- *California v. Texas,* 945 F.3d 355 (2019); *cert. granted,* No. 19-840 (U.S. March 2, 2020)
- Proposed rule, Grandfathered group health plans and grandfathered group health insurance coverage (Federal Register, July 15, 2020)
- FAQs about proposed grandfathered group health plans and grandfathered group health insurance coverage rule (DOL, July 15, 2020)
- Final rule, Nondiscrimination in health and health education programs or activities (Federal Register, June 19, 2020)
- Improvements are needed to ensure employer shared-responsibility payments are properly assessed (TIGTA, June 10, 2020)
- Data note: 2020 medical loss ratio rebates (Kaiser Family Foundation, April 17, 2020)
- Employer shared-responsibility provisions (IRS, April 3, 2020)
- Information reporting by providers of minimum essential coverage (IRS, April 3, 2020)
- Information reporting by applicable large employers (IRS, April 3, 2020)
- Q&As on reporting of offers of health insurance coverage by employers (Section 6056) (IRS, April 3, 2020)

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- Q&As on information reporting by health coverage providers (Section 6055) (IRS, April 3, 2020)
- Q&As on information reporting by employers on Form 1094-C and Form 1095-C (IRS, April 3, 2020)
- Q&As on employer shared-responsibility provisions under the Affordable Care Act (IRS, Feb. 18, 2020)
- ACA FAQs, Part 41 (DOL, HHS and Treasury, Feb. 3, 2020)
- Memorandum 20200801F, Statute of limitations for IRC § 4980H (IRS, Dec. 26, 2019)

Mercer Law & Policy Resources

- Justices' Title VII ruling on LGBTQ bias has health benefit impacts (June 15, 2020)
- 2021 ACA out-of-pocket maximums, ESR penalties, other changes ahead (June 3, 2020)
- Employers face ongoing liability for ACA play-or-pay assessments (March 2, 2020)
- Healthcare law and policy outlook for 2020 (Feb. 18, 2020)
- 2020 quick benefit facts (Jan. 27, 2020)
- Updated 2020 federal poverty levels can impact ESR affordability (Jan. 22, 2020)
- Latest ACA case: Appeals court rules individual mandate unconstitutional (Dec. 19, 2019)
- Cadillac, other ACA taxes repealed in spending bill (Dec. 17, 2019)
- IRS outlines how individual-coverage HRAs can meet ACA employer mandate (Oct. 29, 2019)
- Bipartisan bills would simplify ACA employer-reporting requirements (Aug. 12, 2019)

Other Mercer resources

- Supreme Court's LGBTQ decision spurs legislation, lawsuits (June 18, 2020)
- Historic ruling confirms LGBTQ+ work protections (June 15, 2020)
- Employers will face difficult decisions if ACA ruling stands (Dec. 17, 2018)

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