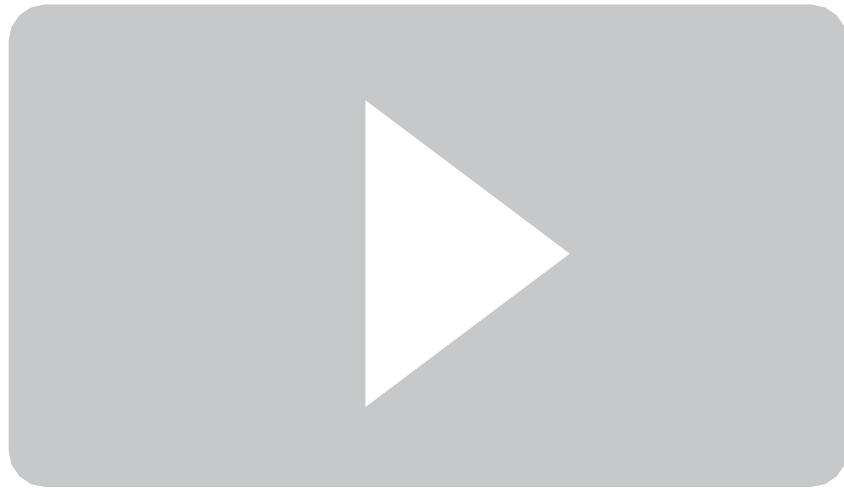

This Webinar Will Start Momentarily.
Thank you for joining us.

2022 Year in Review and Looking Ahead to 2023

January 19, 2023

Presented By:
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Presented by the Regulatory and Legislative Strategy Group

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Group Health Plan Transparency

Surprise Medical Bill Rules

- Applicable beginning with plan years beginning in 2022
- Rules generally apply to all group medical plans (also apply to health care providers)
- Rules apply to three types of claims:
  - Out-of-network (OON) emergency services
  - Services provided by an OON provider during a visit to an in-network facility
  - OON air ambulance services
- Essentially, requires these OON claims to be processed as in-network (IN) claims

Surprise Medical Bill Rules

- Rate that is ultimately paid to the OON provider facility equals:
  - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
  - If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law;
  - If there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility; or
  - If none of those three conditions apply, an amount determined by an independent dispute resolution (IDR) entity
    - IDR entity chooses between the price proposed by the plan and amount proposed by the provider
    - Under new regulations, no presumption in favor of any specific amount

- Recent FAQ guidance (FAQs Part 55) answers the following questions (among others):
  - Do rules apply to plans without networks (e.g., plans that use referenced-based pricing)? Yes
  - Do rules apply to plans that provide no OON benefits? Yes
  - Do rules require plans to provide coverage for OON non-emergency air ambulance claims? Not if the plan does not provide coverage for non-emergency air ambulance services.
  - Do rules apply to emergency services at behavioral health facilities? Maybe

Surprise Medical Bill Rules

NOTICE REQUIREMENTS

- Post information about rules on a public website of the plan or issuer
  - » If a ***plan*** does not have a public website, requirement can be satisfied by entering into a written agreement with a health insurance carrier or a third-party administrator (TPA) that posts the information on the carrier's/TPA's public website that is usually accessible by participants
  - » No requirement to create a public website for plan if agreement is entered
  - » If the insurance carrier/TPA fails to abide by its agreement to post the information on behalf of the plan, the plan is ultimately in violation of the disclosure requirement
- Include information on each explanation of benefits for an item or service with respect to which the surprise billing requirements apply
- No specific requirement to distribute notice to all participants

Transparency Rules

Prohibition on Gag Clauses

- A plan may not enter into an agreement regarding a provider network that would directly or indirectly restrict the plan from accessing or disclosing certain information
- Plan must annually submit to the DOL an attestation that it complies with these requirements
- Currently effective; attestations to be collected in future

Health Plan ID Card Enhancements

- Required to include a deductible, OOP maximum and certain contact information
- Effective for plan years starting on or after 1/1/22

Continuity of Care Requirements

- Plans must ensure continuity of care when contract terminations result in changes in provider or facility network status
- Effective for plan years beginning on or after 1/1/22

Transparency Rules

Provider Directory Requirements

- Establish a database on the plan's public website containing a list of each in-network health care provider/facility with name, address, specialty, telephone and digital contact information (must be kept up-to-date)
- At least once every 90 days, verify and update the provider directory information included in the database for each health care provider and facility
- Establish a protocol to respond to a participant's telephonic (or potentially electronic) request for provider/facility information within one (1) business day
- Conditional protections if a participant receives information indicating a provider/facility is in-network and it is not, from the plan
- Effective for plan years beginning on or after 1/1/22

Transparency Rules

Publicly Available Machine-Readable Files

- One file must include the rates negotiated between the plan and in-network providers for all covered items and services; another file must include data showing the historical payments to, and billed charges from, out-of-network providers; Rx drug file not currently required
- Must be posted by later of 7/1/22 or first day of 2022 plan year and routinely updated
- Applies to group health plans (as well as carriers)
  - » Fully insured plans have no responsibility if the carrier agrees in writing to post the files on behalf of the plan
  - » Self-insured plans can comply by entering a written agreement with TPA to post the files, but the plan remains ultimately responsible for compliance
  - » Link to carrier's/TPA's website only if the plan has its own public website

Transparency Rules

Reporting on Prescription Drug and Other Costs (RxDC Reporting)

- Applies to group health plans regardless of employer size
  - Exemptions for HIPAA excepted benefits and account-based group health plans
- First reports (2) are due 12/27/22 and will cover 2020 and 2021
  - DOL, HHS and IRS relief provides reporting grace period extension of submission deadline to January 31, 2023
  - Good faith enforcement relief for 2020 and 2021 data submissions
- Future reports due by June 1 of the following year (e.g., 2022 report due by 6/1/23)
- Reporting conducted via CMS HIOS

- Current instructions available at: https://regtap.cms.gov/uploads/library/RxDC-Section-204-Reporting-Instructions-06-30-2022.pdf
- Three types of files:
  - Plan List (P2 for group health plans)
    - Each data file must be accompanied by a plan list that identifies the plan or plans for which the data is being filed
  - Data files (D1 through D8):
    - Premiums and Life Years (Covered Lives) – D1
    - Medical Spending by Category – D2
    - Rx Cost Information – D3-D8
  - Narratives

Transparency Rules

Reporting on Prescription Drug and Other Costs (RxDC Reporting)

- Who is responsible for filing the reports?
  - » Carriers and group health plans
  - » Third party can file reports for group health plan if it agrees to do so pursuant to a written agreement
    - – Self-insured plans retain ultimate responsibility
  - » Multiple entities can report on behalf of single plan
- No duplication of data
  - » One data file for each plan with limited exceptions
- Complete data for each plan
  - » Transition Relief: "the Departments will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if those data elements are reported in the RxDC report for the 2022 reference year and all future reference years."
  - » Average monthly premiums are only part of the information included in the D1 file
- P2 and D1 files tend to be sticking points, especially for self-insured plans
  - » If the carrier, TPA or PBM will not agree to submit these files, the plan sponsor must do so

Transparency Rules

Price Comparison Tool (TiC regs)

- Self-service tool available on a public website; paper copy must be provided upon request
- Real-time responses that are accurate as of the date on which the request is made
- Participants must be able to search for information for a covered item or service by a specific in-network provider, by all in-network providers or by out-of-network providers by inputting certain information about the item/service and provider
- Plan sponsor can shift responsibility to a third party via written agreement, but sponsors of self-insured plans retain ultimate responsibility for compliance
- Effective for plan years starting on or after 1/1/23
  - Tool must include 500 items and services by that date
  - All items and services must be included for plan years starting on or after 1/1/24

Price Comparison Tool (No Surprises Act)

- Very similar to TiC requirements, except information must be available by telephone as well
- Awaiting guidance regarding the coordination of two requirements

Transparency Rules

Advanced EOBs

- Plans must issue EOBs in advance of scheduled care
- Triggered by 1) receipt of notice from provider/facility that care has been scheduled; or 2) participant request
- Must be provided not later than either one (1) or three (3) business days (depending on circumstances) after notice/request received
- Information to be provided includes:
  - Whether provider/facility is in-network
  - Various estimates (e.g., the amount the plan is responsible for paying, the amount of any cost-sharing, the amount that the participant has incurred toward meeting deductible and OOP Max, etc.)
  - Certain disclaimers
- Effective as of a future date after rulemaking

Telemedicine & HSA Eligibility

First Dollar Coverage for Telemedicine

Background

- Availability of telehealth benefits typically makes an employee ineligible to make or receive HSA contributions
- Employers with HSA programs that also offer telehealth benefits (either through the HDHP or through a stand-alone telehealth benefit) previously needed to either:
    1. Limit the telehealth benefits available to HDHP enrollees to preventive care until the deductible is satisfied; or
    2. Charge HDHP enrollees who use telehealth services (other than for preventive care) a fee equal to the fair market value of the care until the deductible is satisfied
- CARES Act amendment to Section 223
    - » Applicable for plan years beginning before 1/1/22
    - » Coverage for telehealth and other remote care is disregarded when determining whether someone is eligible for HSA contributions
    - » A group health plan will not fail to be an HDHP solely because it provides coverage for telehealth and other remote care before the satisfaction of the minimum deductible

First Dollar Coverage for Telemedicine

CAA of 2022

- Extended CARES Act relief
- Applies during the period of April 1 through December 31, 2022
  - » Note: Potential gap between 12/31/21 and 4/1/22

CAA of 2023

- Enacted on December 23, 2022
- Extends CARES Act and CAA of 2022 relief
- Applies during plan years starting on or after January 1, 2023, and before January 1, 2025
  - » Note: Potential gap between 12/31/22 and first day of 2023 plan year

ACA Reporting Deadlines

ACA Reporting

Deadlines for Forms 1094/1095-B and 1094/1095-C

Final Regulations Issued in December

- Finalize proposed regulations issued in late 2021 on which employers and plan sponsors were relying
- Permanently extend the deadline for furnishing Forms 1095-B and 1095-C to employees/participants
  - » Deadline is 30 days after January 31 in the following calendar year (or the next business day, if the 30th day falls on a Saturday, Sunday or legal holiday)
  - » March 2, 2023, for 2022 Forms
- Finalize method for an alternative method to furnish Forms 1095-B and, in some cases, 1095-C to employees/individuals

- Must prominently post on the reporting entity's website a "clear and conspicuous" notice with information about how an individual can request the form and furnish the form within 30 days after an individual's request is received
- Notice must be posted by the deadline for furnishing statements and remain in the same location on the website until October 15 of the year following the calendar year to which the statement relates
- Applies to ALEs only with respect to furnishing Form 1095-C to non-full-time employees and non-employees enrolled in the ALE's self-insured health plan; does not apply to furnishing Form 1095-C to full-time employees

Family Glitch Regulations

Family Glitch

WHEN AN EMPLOYEE'S FAMILY MEMBERS MAY QUALIFY FOR PREMIUM TAX CREDITS

Historically

A premium tax credit (PTC) was available to an employee and their family members only if the employee's contribution towards *employee-only coverage* was considered "unaffordable"

- Rule disqualified many spouses and dependents from receiving PTCs even though dependent coverage under employer plan was expensive

Final Regulations Issued in October

Employer-sponsored coverage for certain spouses and dependents is considered affordable for PTC purposes if the employee's annual cost of *family coverage* does not exceed the threshold (indexed for inflation each year) of the employee's household income

- Applicable for tax years beginning after 12/31/22
- Based on the cost of family coverage under lowest-cost MV option
- **No impact on employer shared responsibility penalties or employer ACA reporting**
- Could cause more spouses and dependents to waive coverage

New Exception to Irrevocable Elections

NOTICE 2022-41

Background

- Section 125 of the Internal Revenue Code prohibits mid-year changes to pre-tax elections unless an exception applies
- Previously no exception applied when an employee's spouse and/or dependents enrolled in Exchange coverage

New Exception to Irrevocable Elections

NOTICE 2022-41

New Rule

- Election of family coverage under group health plan (not including health FSA) may be revoked when:
  - » One or more related individuals are eligible for a special enrollment period to enroll in a Qualified Health Plan (QHP) through an Exchange or one or more related individuals seek to enroll in a QHP during the Exchange's annual open enrollment period
  - » The revocation corresponds to the intended enrollment of the related individual(s) in a QHP through an Exchange
  - » QHP coverage must be effective no later than the day immediately following the last day of the original coverage that is revoked
  - » If the employee is not also enrolling in the QHP, they must elect self-only coverage (or family coverage including one or more already covered related individuals)
  - » May rely on the reasonable representation of an employee that the employee and/or related individuals have enrolled or intend to enroll in a QHP through an Exchange
- Applicable to Section 125 elections effective on or after 1/1/23
- Employers are not required to allow these election changes, but if they desire to allow the change, their Section 125 plan must be amended
  - » Amendment must be adopted by last day of plan year in which the new election change is allowed
  - » Special rule when adding new election change in plan year beginning in 2023 – amendment must be adopted by last day of plan year beginning in 2024

COVID-Related Rules

FFCRA and CARES Act

BENEFIT PLAN MANDATES FOR COVID-RELATED CARE

Coverage for Diagnostic/Testing Items and Services (including OTC tests)

- Applicable to all plans (grandfathered and non-grandfathered)
- Applies during the public health emergency declared by HHS (different than National Emergency/Outbreak period discussed later)
- Most recently renewed on 1/11/2023 for another 90 days
- HHS has indicated it will give states at least 60-days advance notice before expiration/termination of the declaration
- When it expires, plans will be able to impose cost-sharing and/or medical management on benefits for COVID diagnostic testing

Preventive Services (Including Immunizations)

- Plans are required to cover COVID immunizations (both IN and OON) without cost-sharing
- Only a portion of the mandate is tied to the public health emergency
  - Permanent – IN coverage for immunizations
  - Will Expire – Requirement to provide coverage for immunizations received at OON providers

Notice 2020-15

HDHP COVERAGE AND COVID CARE

Transition Relief

- Allows HDHPs to provide first dollar coverage for COVID testing and treatment without jeopardizing status as HDHP and without affecting enrollee's HSA eligibility
- Applies until further guidance is issued
- Potentially could end when the public health emergency ends
- Upon expiration, HDHPs will need to be amended

Joint IRS and DOL Rule

RULE ISSUED ON 5/4/20 EXTENDING VARIOUS DEADLINES

Deadlines extended include:

- HIPAA Special Enrollment
- COBRA elections and premium payment grace periods
- COBRA election notice distribution
- Claims deadlines and various appeal and external review deadlines

Timeframes are tolled during Outbreak Period but no longer than one year

- Outbreak Period ends 60 days after end of the National Emergency declared by the President
- Current National Emergency declaration ends February 28, 2023

If National Emergency is not renewed:

- Outbreak Period will end on April 29, 2023
- All tolled periods will begin to run again on that date

Section 125 Plan Relief

Notice 2021-15

- Provided various types of permissible relief for Section 125 plans and FSAs (both Dependent Care and Health Care FSAs) for plan years beginning in either 2020 or 2021
- Relief included:
  - » Unlimited carryovers
  - » Extended grace periods
  - » Less restrictive mid-year election changes
  - » Incurred expense relief for Health Care FSA for terminated employees
  - » Dependent care expense reimbursement for “aged out” dependents
- If employer took advantage of relief, Section 125 plan must be amended
  - » For any such change effective with respect to a plan year ending in 2021, the written plan amendment must have been adopted by December 31, 2022
  - » For any such change effective with respect to a plan year ending in 2022, the written plan amendment must be adopted by December 31, 2023

On the Horizon?

EEOC Regulations Under ADA

Background

- Wellness programs that request medical information or involve medical testing are subject to ADA (e.g., programs that involve HRAs or biometric testing)
- Provision of medical information must be voluntary
- Previously issued ADA regulations identified a number of conditions that must be satisfied for a program to satisfy the voluntary requirement
- One condition related to the amount of incentive/reward that may be provided
- EEOC removed that portion of regulations because court invalidated it
- Subsequent amended regulations were withdrawn by Biden Administration

New ADA Regulations Are Expected Any Time

- Until they are issued, the amount of incentives/rewards that may be provided for participating in a wellness program subject to the ADA is unclear
- Need to discuss with legal counsel

Similar Situation with GINA

- A portion of the GINA regulations applicable to wellness programs was ruled invalid
- New GINA regulations should be forthcoming

Things to Look for in 2023

1

Ground Ambulance Surprise Billing

Federal Advisory Committee established to provide recommendations to regulatory agencies

2

Mental Health Parity

House-passed bill expands DOL's ability to sue plans and insurers and impose monetary penalties for violations

3

PBM Regulation

Proposed legislation requires PBMs to report data to plan sponsors; many states considered legislation in 2022 and/or have created drug affordability boards

4

Rx Drug Regulation

Oct. 2022 Executive Order with purpose of lowering drug costs; Proposed legislation caps copays for insulin

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