2023

Employee Benefit Regulatory Update

Presented by Benefit Comply

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Agenda

- Health Cost Transparency Update
  - RxDC Reporting
  - Gag Clause Attestation
  - Air Ambulance Reporting
- Other Regulatory Developments
  - Employer Reporting Electronic Submission
  - End of non-federal opt-out for MHP
  - Telehealth and HSAs
  - DOL Cyber Security Guidance
- Family Plan Affordability – Fixing the “Family Glitch”
- Preview of End of Public and National Emergency Rules

Health Cost Transparency Rules Update

Transparency Requirements Overview

2021

January 2021

Hospital Cost Reporting

2022

January 2022

No Surprises Act

No Gag Clauses in Contracts

Continuity of Care

ID Cards

Provider Directory Accuracy

July 2022

Carriers & Plan Release
Health Plan Cost Data
Machine Readable Files

December 2022

Rx & Health Care Spending Reporting (Dec. 27, 2022)

2023

January 2023

Price Transparency Tools - 500 Items & Services

2024

January 2024

Price Transparency Tools - All Items & Services

Delayed Until Additional Guidance Is Released

Prescription Cost Data Machine Readable File

Provider treatment cost estimate and Advanced EOB

Prescription Drug Data Collection (RxDC) Background

- What?
  - Insurance companies, PBMs & employer-based health plans must annually submit information about prescription drugs and health care spending
  - Reporting for employer plans consists of 9 required data files to be submitted electronically to the Centers for Medicare and Medicaid Services (CMS)
    - Data is submitted through the HHS Health Insurance Oversight System (HIOS) Portal
    - Required for all group health plans, but not for account-based plans (e.g., Health FSA or HRAs) or excepted benefits (e.g., limited-scope dental or vision)
- Why?
  - Federal Government will issue annual report with the goal that the data can be used to help lower drug costs
- When?
  - First report was due December 27, 2022 for Rx data for calendar year 2020 and 2021
  - Reporting then required annually by June 1 beginning 6/1/2023 (for 2022 data)

Prescription Drug Data Collection (RxDC) Background

- Reporting Includes:
  - Total Rx spending
  - 50 most common brand prescription drugs paid by the plan
  - 50 drugs with greatest cost increase
  - Claims paid for each of the 50 most costly drugs
  - Rebate Data
  - TPA and PBM fees
  - Total spending by types of cost (e.g., hospital, primary care, specialty care, prescription drugs)
  - More

- Employer Plan Related Data Files
  - P2. Group health plan list
  - D1. Premium and Life-Years
  - D2. Medical Spending by Category
  - D3. Top 50 Most Frequent Brand Drugs
  - D4. Top 50 Most Costly Drugs
  - D5. Top 50 Drugs by Spending Increase
  - D6. Rx Totals
  - D7. Rx Rebates by Therapeutic Class
  - D8. Rx Rebates for the Top 25 Drugs

RxDC Reporting – Round Two!

Round 1

- Reported 2020 & 2021 calendar years
- Originally due December 27, 2022
  - Deadline extended to January 31, 2023

Round 2

- Reporting 2022 calendar year

Employer Responsibility By Type of Plans Offered

In Round 1 most employers relied on vendors to do the reporting – However some self-insured employers had to do part of the reporting themselves

- Self-Insured With Integrated Vendor
  - Employer uses a single vendor to handle all prescription drug claims
    - Most TPAs did all required filing
    - Some TPAs will file most of the substantive files (e.g. D2- D8) but expect the employer to submit one or more files - Most commonly the D1 file (Premium & Life Years)
- Self-Insured with Separate, Multiple, or Carve-out Vendors
    - The employer will need to work with their vendors separately to complete the filing
    - A common scenario was TPA submitted D1 & D2 files, the PBM submitted the rest
    - Some vendors also required the employer to submit certain files - Most commonly the D1 file (Premium & Life Years) and accompanying P2 file

RxDC – The Process

“Reporting Entities” must set up account in CMS HIOS system

- Multiple entities may report for a single plan (e.g., TPA, PBM, employer)

Submit a plan file, 8 separate data files, and narratives

- Determine who has the necessary data and ensure all files and narratives are completed

Confirm submissions

- No way to confirm in CMS HIOS system, so employer will need to confirm with vendors whether data is reported

Rx Reporting Responsibility Revisited – Round 2

- What's Changing in Round 2?
  - In Round 1 carriers & TPA did not have to submit some employer in the D1 file
  - Beginning in round 2 this data must be submitted – and the carrier or TPA does not have all of the necessary data

The D1 File

	A	B	C	D	E	F
1	Issuer or TPA Name	Issuer or TPA EIN	State	Market Segment	Average Monthly Premium Paid by Members	Average Monthly Premium Paid by Employers

G	H	I	J	K
Life Years	Earned Premium	Premium Equivalents	ASO/TPA Fees Paid (included in the Premium Equivalents field)	Stop Loss Premium Paid (included in the Premium Equivalents field)

All employers – even fully-insured – will likely have some role to play in completing Round 2 reporting

RxDC Reporting Round 2

- How Involved will Employer Be with Reporting Going Forward?

- Approach #1
  - Some Carrier/TPAs require employer to report average monthly premium and sometimes other data to the carrier through online form, email, or paper form

- Approach #2
  - Employer must file their own D1 file and the carrier or TPA submits the rest
    - Employer will also need to submit a P2 along with the D1
  - If employer has to file the D1 themselves, they will first need to register with HIOS if they have not done so already

Gag Clause Prohibition

- Background
  - Effective in 2020, group health plans and health insurance carriers are prohibited from entering into agreements with providers, TPAs, or other service providers containing gag clauses

What is a Gag Clause?:
Contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party

  - Might exist in agreements between the plan and:
    - a health care provider;
    - a network or association of providers;
    - a TPA; or
    - another service provider offering access to a network of providers

Gag Clause Prohibition

- Attestation Requirement
  - Plans are required to attest to compliance
    - Plans of all sizes, fully-insured and self-funded, grandmothered and grandfathered
    - Does NOT apply to excepted benefits or account-based plans (e.g., HRAs)
    - The Departments have launched a website for submitting the Attestation https://hios.cms.gov/HIOS-GCPCA-UI
  - Due Date for Attestation
    - December 31, 2023 then annually after that
  - Responsibility for Attestation
    - **Most employers will rely upon carrier or TPA to handle the attestation**
    - Employer should have something in writing indicating carrier or TPA will comply
    - Employers handling any of their own contracts will need to attest on their own

Air Ambulance Reporting

- Background
  - No Surprises Act (NSA) includes provision requiring carriers and health plans to report air ambulance claims info to CMS
    - Used to issue public reports on what drives the high costs of these services
- Reporting Effective Date
  - Original proposed due date for first report was March 31, 2023
  - The NSA states that reporting will not begin until 90 days after the first full year following the issuance of final rules…The final rules have not been issued
  - The earliest that reporting could be due is March 2025 (if final rules are released by end of 2023)

Other Regulatory Developments

Employer Reporting

- Previous Rule - electronic filing of Forms 1094/1095 required for employers filing 250 or more ACA reporting forms.

New Rule - In 2024, electronic filing of Forms 1094/1095 required for:

- Employers filing 10 or more returns
  - “Returns” – includes Form 1094/1095, Forms W-2, 1099, 940, 941, income tax returns, excise tax returns, employment tax returns

End of non-federal opt-out for MHP

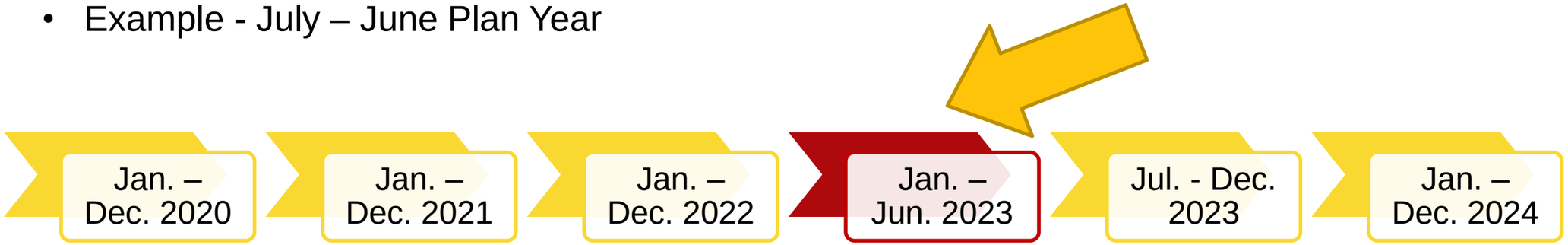
- Previously: non-federal governmental self-insured plans could opt out of mental health parity requirements (after election to opt out)
- CAA 2023 eliminated the opt-out right – as of December 29, 2022:
  - No new opt-out elections may be made
  - Any opt-out elections expiring 180 days or more after December 29, 2022 may not be renewed

Telemedicine and HSA Eligibility

- Background
  - In order to be eligible to make, or receive, HSA contributions:
    - Must be covered a qualified HDHP
    - Cannot have “Disqualifying Coverage”
      - Coverage that reimburses medical expenses (other than preventive) before individual has met minimum HSA qualified HDHP deductible is met (e.g. other health insurance coverage, Medicare, Health FSA, Telemedicine, etc.)
- History of Temporary Relief
  - 2021 CARES Act temporary relief from this requirement for 2021
  - 2022 Consolidated Appropriations Act (CAA) extended relief for part of 2022
    - Expired December 31, 2022
  - 2023 Consolidated Appropriations Act (CAA) again extended relief for 2023 and 2024…

Telehealth & HSA-Eligibility

- 2023 CAA Relief for HSA-Eligibility Extended for 2023 and 2024
  - Problem with the structure of relief
    - The old telemedicine/HSA relief ends as of December 31, 2022
    - The new relief in 2023 CAA does not begin until the start of the 2023 plan year
  - Calendar Year Plan
    - Participant with disqualifying telemedicine coverage will still be HSA eligible for all of calendar year 2023 and 2024
  - Non-Calendar Year Plans
    - Participants with disqualifying telehealth coverage HSA ineligible until start of 2023 plan year
    - Example - July – June Plan Year



DOL Cybersecurity Guidance

- Released in 2021 as “Best Practices” – NOT official guidance/regulation
  - Guidance may be found here (in 3 parts): https://www.dol.gov/newsroom/releases/ebsa/ebsa20210414

  Breaking News – The DOL has been asking about cybersecurity practices during ERISA audits…

- What is an employer to do?
  - Be aware that the DOL is paying attention to cybersecurity practices
  - Its “best practices” does not have force of law, but shouldn’t be ignored either
  - Review existing practices in light of guidance - consider plugging in any gaps
- It is time for employers to reconsider adopting up-to-date HIPAA Security Policies and Procedures
  - If employers have fully complied with HIPAA security rules (security risk analysis, policies, etc.), they will be addressing much of the DOL cyber security best practices!

Family Plan Affordability Change

Change to “Family Glitch”

- IRS has changed the definition of affordability for the purpose of qualification for premium tax credits when purchasing individual coverage through the public Exchange
- Old Rule:
  - Affordable for employee **and all eligible family members if single coverage is affordable**
  - Employee contribution for single coverage cannot exceed 9.12% (2023) of household income
- New Rule effective 01/01/2023
  - Affordability for employee based on employee contribution for single coverage (cannot exceed 9.12% of household income)
  - **Affordability for family members based on employee contribution for family coverage** (cannot exceed 9.12% of household income)
  - Affordability for the employee will still be based on the cost for the employee to participate in single (employee-only) coverage

How Many Employees Could This Impact?

- When is Family Contribution Unaffordable?

Using 2023 9.12% Affordability			
Mo. Employee Contribution for Family Coverage	$500.00	$750.00	$1,000.00
Unaffordable for Household Incomes Under	$65,789.47	$98,684.21	$131,578.95

IMPORTANT NOTE:

Employers are not required to offer affordable family coverage

Employer will not be penalized for unaffordable family coverage

Proposed Family Glitch Fix Example

Monthly Total Premium Cost:

- Employee-only (single) coverage = $500
- Family coverage = $1,500
- Employee's Household Income = $120,000 ($10,000/mo.)
- 9.12% of $10,000 = $912

Example 1 - Monthly EE Contribution

Single = $250, Family = $1,100

- Current Rule - Affordable for employee and all family members
- New Rule - Affordable for employee, but not for family members
  - (> 9.12% of income)

Example 2 - Monthly EE Contribution

Single = $250, Family = $750

- Current Rule - Affordable for employee and all family members
- New Rule - Affordable for employee and all family members

End of National Emergency Preview

Public Health Emergency & National Emergency

There are Two Different Kinds of Pandemic Related "Emergencies"

- The Public Health Emergency
  - Declared by the Dept. of Health and Human Services January 2020 and renewed every three months.
  - Plan coverage for COVID vaccination and testing, standalone telehealth, Medicaid rules.
  - Administration has announced planned end of Public Health Emergency effective May 11, 2023
- National Emergency
  - First Declared by President Trump March 2020 and renewed annually since then
  - Outbreak Period = National Emergency + 60 days
  - Administration has announced planned end of National Emergency May 11th, 2023 - Outbreak period would expire July 12th, 2023

Public Health Emergency Ending

- Benefits Related Issues Affected by the of the Public Health Emergency
  - Changes that could begin taking effect as soon as May 11, 2023
    - Coverage for vaccinations at 100%
    - Coverage for COVID diagnostic testing
    - Coverage for COVID treatment
    - Stand-alone telehealth arrangements
      - Temporary relief for stand-alone telehealth will be ending making it riskier for employers to continue offering stand-alone telehealth
  - Medicaid Eligibility
    - Those who no longer meet state eligibility criteria will likely lose coverage (some states are choosing to take action more quickly than others)

End of National Emergency and Outbreak Period

- Benefits Related Issues Affected by the of the National Emergency
  - Changes that could begin taking effect as of July 12, 2023 – the end of the Outbreak Period
    - End of extension on ERISA claims and appeals (including extended deadlines for claiming FSA and HRA reimbursement)
    - End of extension for requesting HIPAA special enrollment rights
    - End of extension for electing and paying for COBRA continuation coverage
    - End of extension on providing COBRA notices (for the plan and for participants)
    - No more broad flexibility on timing of employer notices and ability to provide notices electronically without meeting the DOL safe harbor

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