COMPLIANCE ALERT

Get Your Employer-Sponsored Group Health Plan Ready for 2023

EPIC Insurance Brokers & Consultants

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Quick Facts

- There are several important considerations that group health plan sponsors must think about for 2023.
- Changes to the Affordable Care Act (ACA) may impact plans next year.
- The Internal Revenue Service (IRS) increased plan contribution rates for spending accounts and minimum deductibles high deductible health plans (HDHPs).
- Two Supreme Court decisions in 2022 may impact employer group health plan designs moving forward.
- Gender discrimination continues to be an important topic.

Background

2022 is winding down. Below is a list of considerations for 2023 to ensure you are ready for any new requirements coming up in the new year.

Affordable Care Act

Affordability

Under the ACA, applicable large employers (ALEs) are required to comply with the employer shared responsibility rules under §4980H, which requires employers to offer minimum value, affordable coverage to full-time employees and their dependent children. Generally, coverage is considered "affordable" when the cost for self-only coverage does not exceed the percentage set by the Internal Revenue Service. This percentage is updated annually. In 2023, the percentage will be 9.12% of household income. Coverage is also considered "affordable" for purposes of satisfying §4980H(b) requirements so long as the employee contribution satisfies at least one of three available safe harbors: federal poverty level (FPL), rate of pay, or Form W-2.

ALEs should review affordability annually to determine the potential risk for penalties due to offering unaffordable coverage.

Preventive Services

Under the ACA, non-grandfathered health plans must provide coverage for preventive services at no cost sharing in-network. The list of required preventive services is updated periodically. With the exception of services related to COVID-19, coverage at no cost sharing for services that are added, or existing services that are updated, beginning at the plan year one year after the recommendation is made or updated.

For plan years beginning on or after December 30, 2022, **updated guidelines** expand preventive services for women for the following services:

- Breastfeeding services and supplies
- Contraception
- Counseling for sexually transmitted infections
- Screening for Human Immunodeficiency Virus (HIV)
- Well woman preventive office visits
- Obesity prevention for women ages 40 to 60

Group health plan sponsors should be ready to cover these services at no cost sharing and make sure that summary plan descriptions (SPDs) and summary of benefits coverage (SBCs) reflect coverage at no cost sharing for these services

Consolidated Appropriations Act

On December 27, 2020, Congress passed the Consolidated Appropriations Act of 2021 (CAA) into law, establishing protections for consumers related to surprise billing and transparency in health care.

Mental Health Parity NQTL Comparative Analysis

Part of the CAA requires that group health plan (GHP) sponsors must document, and make available upon request, an analysis of the plan's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) non-quantitative treatment limitation (NQTL) requirements.

The MHPAEA requires a GHP to provide the same level of benefits for mental health and substance use disorders (MH/SUD) as medical and surgical (M/S) care, which includes parity for NQTLs. The CAA amends the Employee Retirement Income Security Act (ERISA), the Public Service Health Act (PHSA), and the Internal Revenue Code (IRC) to require GHPs to provide a formal analysis of NQTLs to the Departments upon request.

The new rules went into effect on February 10, 2021, with additional guidance released in April 2021. We expect to see additional guidance from the Departments on the analysis requirements in the future, but the rules are in effect and plan sponsors should work to comply with their requirements. For more information see our **March 2021** and **May 2021** EPIC Compliance Matters alerts.

Prescription Drug Data Collection Reporting

As part of the CAA, employer-sponsored health plans are required to submit certain information about prescription drug and healthcare spending to the Centers for Medicare and Medicaid Services (CMS) annually called the Prescription Drug Data Collection Report (RxDC). The Department of Labor (DOL) the Department of Health and Human Services (HHS) and the Treasury Department (collectively, the Departments) intend to use this information to issue public reports on prescription drug pricing and trends beginning in 2023. The first report for "reference years" 2020 and 2021 is due December 27, 2022. Subsequent reports will be due each June 1.

The interim final rule (IFR) requires employer-sponsored health plans and carriers to submit certain information on prescription drug and other healthcare spending to the Departments each year. The instructions break down the required information into two categories, Plan Lists (P) and Data Lists (D). In some cases, a narrative response is required.

The reporting responsibility ultimately lies with the group health plan sponsor, but the carriers, third party administrators (TPAs) and pharmacy benefit managers (PBMs) will have most of the information necessary to submit the required data on behalf of employer-sponsored plans. There may be data that these organizations do not currently have in their systems, which will require coordination with employers to collect the necessary information. Vendor involvement with the reporting will vary.

Fully insured plans should be able to rely on the carrier to submit all required data to satisfy the requirement. Fully insured plan sponsors should obtain, in writing, the responsibility of the carrier to report.

Self-funded plan sponsors should contact their TPAs and PBMs to determine what assistance these vendors will provide. They should also review any service agreement provisions regarding reporting responsibility, liability for errors or failure to report, and any fees that might be incurred for the additional responsibility.

Machine Readable Files

Starting July 1, 2022, as part of the Transparency in Coverage (TiC) signed into law in 2020, plans must post on a publicly accessible website, pricing data on certain healthcare items and services known as the "machine-readable files" or "MRFs." The intent is that insurance companies and self-funded health plans publicize what they pay providers for medical services. Updated guidance released in August 2022 clarified that as long as there is a written agreement in place, an employer is not required to post on their own organization's public website a link to files that are made public by the carrier or employer's plan administrator.

The TiC Final Rule requires the machine-readable files to be accessible free of charge, without having to establish a user account, password, or other credentials, and without having to submit any personally identifying information such as a name or email address. The machine-readable files must be updated monthly and must be available in a form and manner specified in any guidance issued by applicable regulatory agencies.

Plan sponsors who have not posted the MRF on their own publicly accessible website should confirm with their carriers or third-party administrators (TPAs) that the MRF is posted on a machine-readable file.

Supreme Court Decisions

Dobbs v. Jackson Women's Health

As noted in our **June 2022 Alert**, we explained the Supreme Court's decision in *Dobbs v. Jackson Women's Health* will have wide ranging implications regarding how states will permit, restrict or ban abortions. It is therefore extremely important that group health plan sponsors become aware of the laws in the states where they operate. The impact of the Dobbs decision on medical plans remains unclear, and it is widely believed that protracted litigation will follow from the decision. Changes to state laws and various taxation issues present risks to any decisions made by group health plan sponsors, and they are encouraged to seek guidance from their own legal and tax counsel.

Plan sponsors should consider the various ways that they can assist employees with reproductive healthcare while remaining compliant with changing state laws.

Davita v. Marietta Hospital

In June 2022, the Supreme Court released an **opinion** stating that group health plans may limit coverage for dialysis on a uniform basis for all plan participants without violating Medicare Secondary Payer (MSP) rules. For individuals eligible for Medicare due to end stage renal disease (ESRD) the MSP rules require that the group health plan must pay primary to Medicare for the first 30 months of ESRD-based Medicare eligibility, and the group health plan cannot differentiate benefit offerings for those with ESRD (and eligible for Medicare) from those who do not have ESRD.

The language in the MSP rules makes it clear that there cannot be any differentiation in how a group health plan provides coverage based on the existence of ESRD (before, during or after the 30-month coordination period), other than allowing the plan to pay secondary to Medicare once the 30-month coordination period is exhausted. the Supreme Court of the United States (SCOTUS) ruled that when the coverage limitations apply uniformly to all participants requiring such treatments or services, and not just those with ESRD, it does not violate MSP rules.

Benefits Plan Design

Out-of-Pocket Maximum Limits 2023

On April 28, 2022, the Department of Health and Human Services (HHS) released the final 2023 Notice of Benefit Payment Parameters (NBPP) along with a **press release** and **fact sheet** outlining several requirements affecting the Exchanges, provider networks and group health plans.

Of note for group health plans are changes to out-of-pocket maximum limits under the Affordable Care Act (ACA). For plan years beginning in 2023, the maximum annual out-of-pocket limit on cost-sharing will be $9,100 for self-only coverage and $18,200 for other than self-only coverage. This is a significant increase from the 2022 limits, which were $8,700 for self-only coverage and $17,400 for other than self-only coverage.

Plan sponsors should review the plan designs for plans years starting January 1, 2023, and later to ensure compliance with plan limit changes.

Essential Health Benefits

The NBPP includes a requirement for plan years starting January 1, 2023, and later, stating that both individual and group health plans that cover essential health benefits (EHBs) must use clinical evidence to support plan design and any limitations on coverage. Plan sponsors should be ready to document such standards if challenged.

High Deductible Plan Limits 2023

In Spring 2022, the IRS released **Revenue Procedure 2022-24**, which includes the 2023 inflation-adjusted amounts for health savings accounts (HSAs) and high deductible health plans (HDHPs). Starting in 2023, the HSA annual contribution limit for an individual with self-only HDHP coverage will increase by $200 to $3,850. The annual contribution limit for an individual with family HDHP coverage will increase by $450 to $7,750.

The minimum required deductible amounts are increasing for HSA-compatible HDHPs, from $1,400 (self-only coverage) and $2,800 (family coverage) in 2022 to $1,500 (self-only coverage) and $3,000 (family coverage) in 2023. Note the deductible does not apply to certain preventive care services. Plans that embed the deductible for a qualified HDHP must set the embedded limit to at least the family HDHP minimum deductible amount ($3,000). Out-of-pocket maximum limits for HDHPs will increase to $ 7,500 for self-only plans and $15,000 for family plans.

Plan sponsors should review the plan designs for plans years starting January 1, 2023, and later to ensure compliance with plan limit changes.

Flexible Spending Account Limits 2023

In **Revenue Procedure 2022-38**, the IRS sets updated health FSAs and qualified transportation fringe benefits limits for 2023. The limit on annual employee contributions toward health FSAs for 2023 is $3,050, an increase from $2,850 in 2022 with the ability to carryover up to $610, up from

$570 in 2022. The limit on monthly contributions toward qualified transportation and parking benefits for 2023 is $300. Annual Dependent Care Assistance Program (DCAP) reimbursement limits remain at $5,000 for single taxpayers and married couples filing jointly, or $2,500 for married people filing separately.

COVID-19 Considerations

Public Health Emergency

Effective October 13, 2022, the Department of Health and Human Services (HHS) announced another 90-day extension of the **Public Health Emergency** (PHE) regarding the COVID-19 pandemic. This new announcement extends the PHE through January 10, 2023. The first PHE was effective January 31, 2020, and has been renewed 11 times. The announcement means that group health plans must continue to cover COVID-19 diagnostic tests and related services to plan participants at no cost-sharing.

Plan sponsors should stay aware of PHE renewals to remain compliant with COVID-19 testing and vaccine requirements.

Outbreak Period

On February 18, 2022, President Biden **formally extended** the COVID-19 National Emergency extending several notice and disclosure deadlines. The rules apply broadly to all employer-sponsored benefits subject to the Health Insurance Portability and Accountability Act (HIPAA), the Employee Retirement Income Security Act (ERISA) and the Consolidated Omnibus Budget Reconciliation Act (COBRA). The guidance applies for the period of time beginning March 1, 2020, until 60 days after the National Emergency is over (the “Outbreak Period”). All group health plans must disregard this period when administering plans with respect to notices, disclosures and other deadlines covered by the rule.

Plan sponsors should be aware that the national emergency remains in effect and certain deadlines have been extended. It is possible that President Biden may further extend the National Emergency in 2023.

Considerations for Gender Discrimination

Coverage for gender-related treatment and services is an evolving issue. Over the past decade, legislation, regulations, and court decisions all suggest that failure to provide equal access to coverage based on gender or sexual orientation may violate various nondiscrimination laws. Group health plans that exclude or limit coverage for gender affirming care (e.g., care related to gender identity or gender dysphoria) risk discrimination claims on the basis of sex and transgender status in violation of the Constitution’s Equal Protection Clause, Title VII of the Civil Rights Act of 1964 and the Affordable Care Act’s §1557 nondiscrimination rules.

In 2020, in the case *Bostock v. Clayton County,* SCOTUS ruled that Title VII protection against employment discrimination based on sex extends to discrimination based on an individual’s sexual orientation or gender identity.

The ACA §1557 nondiscrimination rules prohibit covered entities from denying or limiting coverage or imposing additional cost-sharing in health insurance and other health-related coverage based on race, color, national origin, sex, age, or disability. Proposed rules issued in July 2022 interpret “covered entities” to include those entities that receive federal funding and that are principally engaged in providing health programs or activities. Insurance carriers, third party administrators (TPAs), and employers in the medical field may be considered covered entities, but most other

employers are not. While employer-sponsored group health plans generally do not receive federal funding, insurance carriers and TPAs may be permitted to issue and administer plans that comply with §1557 nondiscrimination rules.

Group Health Plans subject to §1557 or Title VII risk claims of discrimination for any limits or exclusions tied to gender identity or gender dysphoria, and therefore should make careful considerations before limiting or excluding coverage related to gender identity or gender dysphoria.

EPIC Employee Benefits Compliance Services

For further information on this or any other topics, please contact your EPIC benefits consulting team.