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EPIC Compliance Webinar: Get Ready for 2023!

Compliance Series

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EPICBROKERS.COM

Presenters

Liz Mann, J.D. EPIC Director of Compliance
Liz Mann is EPIC's Internal Compliance Director. Liz and her team are responsible for disseminating information to clients about changing requirements and regulations and reviewing all plan designs and programs for compliance with Federal and State regulations. Liz is embedded into our account management team to provide timely support and guidance as ERISA-related regulations or concerns emerge in the marketplace. As a client, you have the option of directly accessing Liz or accessing her traditionally through your account team. Liz graduated Magna Cum Laude from Saint Mary's College in Notre Dame, IN with Bachelor of Arts degrees in History and French. She graduated with her law degree from University of Toledo, College of Law in Toledo Ohio in 2007. She has accumulated over 14 years of experience working in employee benefits and offers expertise in ERISA, IRS, COBRA, FMLA and ACA compliance.

Andreena Norfleet, EPIC Compliance Consultant
Andreena Norfleet is EPIC's Internal Compliance Consultant. Andreena assists clients by providing updates with the latest news from State and Federal regulators as well as reviewing plan designs for compliance. Andreena Norfleet is a double Panther - graduating magna cum laude from Georgia State University with a Bachelor of Arts degree and in 2022, she obtained her law degree from Georgia State University College of Law. Prior to law school, Andreena managed a private urgent care clinic with 3 locations across the metro-Atlanta area, overseeing the company's compliance and revenue-cycle management departments.

1

Consolidated Appropriations Act of 2021

Mental Health Parity NQTL Analysis

RxDC Reporting

No Surprises Act

Mental Health Parity Analysis

Background

- Starting February 10, 2021, group health plans that provide coverage for mental health or substance use disorder benefits and are therefore subject to mental health parity rules are required to prepare a comparative analysis of the plan's non quantitative treatment limitations (NQTLs)
- The analysis must be provided upon request
- The Agencies only give about 2 weeks to provide the analysis
- Carriers will provide the completed analysis but self-funded TPAs will only provide the data required to complete the analysis, not the analysis itself

Information Included in the Analysis:

- A clear description of the specific NQTL plan terms and policies at issue
- Identification of the specific benefits to which the NQTL applies within each benefit classification
- Identification of any factors, evidentiary standards or sources, strategies or processes considered in the design or application of the NQTL along with their definitions
- Factors used for establishing variation between application of mental health benefits and medical/surgical benefits
- The nature of the decisions made during application of NQTLs
- Decisions made, and the qualifications of the decision maker(s)
- Whether the plan's or issuer's analysis rely upon any experts
- A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources
- The date of the analysis and the name, title, and position of the person or persons who performed or participated in creating the comparative analysis

Prescription Drug Data Collection Reporting

RxDC

- Starting in 2022, plan sponsors must report certain prescription and healthcare spending data annually
- First report was due December 27, 2022, for calendar years 2020 and 2021 and then June 1 annually
- Reported data includes:
  - General information regarding the plan or coverage
  - Enrollment and premium information, including premiums paid by employees versus employers
  - Total health care spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs and other medical costs), including Rx spending by enrollees versus employers and carriers
  - The 50 most frequently dispensed brand prescription drugs
  - The 50 costliest prescription drugs by total annual spending
  - The 50 prescription drugs with the greatest increase in plan expenditures from the previous year
  - Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or carrier in each therapeutic class of drugs, as well as the 25 drugs that yielded the highest amount of rebates
  - The impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs
- The ultimate responsibility to report belongs with the plan sponsor, but Carriers, TPAs, and PBMs will have most of the information necessary to complete the submission
- Plan sponsors need to coordinate what information is being reported by various entities and confirm the submission was completed by the deadline
  - Fully insured plans should obtain confirmation in writing that the carrier will submit
  - Self-funded plans may have more responsibility to submit depending on various vendor involvement

Prescription Drug Data Collection Reporting

Guidance Released December 23, 2022

- The Departments released a set of FAQ guidance a few days before the first filing deadline that included:
  - A grace submission grace period until January 31, 2023
  - Good faith relief for those entities who show a reasonable interpretation of the regulations and RxDC instructions when completing their submission
  - Clarification on:
    - Email submission allowed for employers submitting only a P2 file and a D1 file containing only premium and life years information and/or a narrative response
    - Multiple submissions by the same reporting entity now allowed
    - Data aggregation relief
    - Reporting on vaccines not required
    - Health care and prescription amounts not applied to deductibles or OOPMs no longer required

No Surprises Act

Prohibition on Balance Billing

- Effective January 1, 2022, participant cost sharing for out-of-network emergency services, out-of-network air ambulance services, and certain non-emergency services furnished by out-of-network provider at in-network facilities cannot be higher than in-network cost sharing for these services, and must be counted against in-network deductibles and out-of-pocket maximums
  - Providers cannot balance bill the participant for amounts in excess of cost sharing
- Amount the plan must pay the provider is determined by state law (if any), amount the plan and provider agree to, or independent dispute resolution process
- Participants can sign a consent waiver that gives the provider prior consent to issue them a balanced bill in certain situations
- Plans must provide notice of the new balance billing limitations on their public website (or Carrier/TPA website)
  - The DOL has provided a model notice for this purpose
  - Guidance released in 2022 states that Carriers and TPAs may provide the model notice on behalf of plan sponsors

No Surprises Act

Air Ambulance Reporting

- Requires health plans and health insurance issuers to disclose certain data to the Department of Health and Human Services (HHS) regarding the use of air ambulance services for two years
- Proposed rules were released in fall 2021, no final rules yet
- 2021 proposed rule deadline is 90 days after the end of the applicable calendar year
  - Original intent of the rules was for reporting to begin in March 2023 pending final rules being published in 2021
- No instructions on how to report have been published
- Fully insured plans can rely on the carriers to report on their behalf
- Self-funded plans will need to lean on TPAs to comply
  - Reach out to TPAs to confirm they will report on the plan's behalf once the final rules are published

No Surprises Act

New Identification Cards

- ID cards must state the plan deductible and out-of-pocket maximum limit and contact information such as a phone number and website address for further assistance.
- Plans should use a good faith, reasonable interpretation of the requirements to comply with this rule until additional rule making is provided

Provider Directories

- Plans must provide accurate provider directories online and by telephone, and updated directory information every 90 days
- Plans who provide inaccurate information that is relied on by an individual must pay in-network cost sharing for that individual
- Plans should use a good faith, reasonable interpretation of the requirements to comply with this rule until additional rule making is provided

Continuity of Care

- When a provider or facility is no longer in-network, plan participants must be permitted to elect continuing care for up to 90 days from that provider or facility under the same terms and conditions that were in place prior to the change in network or coverage
- Plans should use a good faith, reasonable interpretation of the requirements to comply with this rule until additional rule making is provided

Transparency in Coverage

Machine Readable Files

Pricing Transparency Tool

Transparency in Coverage

Machine Readable Files

- Effective July 1, 2022, plan sponsors were required to post "machine readable files" (MRFs) providing cost data for covered items and services on a publicly accessible website
- Guidance from HHS confirms that plan sponsors may rely on their carrier or TPA to post the MRF on their own public website

Pricing Transparency Tool

- Starting January 1, 2023, plan sponsors are required to make available an online price transparency tool providing cost information for 500 items and services listed by CMS
- Starting in 2024, the price transparency tool must list all covered items and services
- Plan sponsors must lean on their carriers and TPAs for compliance assistance
    - Confirm in writing that your carrier or TPA is providing this tool

IRS Updates

New Maximum Limits for Health Plans & Accounts

Changes to ACA Affordability

New IRS Limits for 2023

Benefits Plan Limits Comparison (2022-2023)				
Health Flexible Spending Accounts (Health FSA)	**2022**		**2023**	
Health FSA Maximum Contribution (per plan year)	$2,850		$3,050	
Health FSA Maximum Carryover (per plan year)	$570		$610	
Health Savings Accounts (HSA)	**2022**		**2023**	
	Self-Only	Family	Self-Only	Family
HSA Maximum Contribution	$3,650	$7,300	$3,850	$7,750
HSA Maximum "Catch-Up" Contribution (age 55 or older)	$1,000	$1,000	$1,000	$1,000
High-Deductible Health Plan (HDHP) Minimum Deductible	$1,400	$2,800	$1,500	$3,000
HDHP Maximum Out-of-Pocket	$7,050	$14,100	$7,500	$15,000
Qualified Transportation Benefits	**2022**		**2023**	
Parking	$280/month		$300/month	
Transit Pass/Commuter Vehicle	$280/month		$300/month	

Changes to Affordability and "The Family Glitch"

Current Rule

- Affordability for the employee and the entire family is based only on the cost for the employee to participate in single (employee only) coverage

New Rule

- Affordability for the family members will be based on the cost to elect family coverage
- Affordability for the employee will still be based on the cost for the employee to participate in single (employee only) coverage

Effect on Employers

- No change to penalties or risks for penalties under the affordability requirements of ACA's employer mandate (penalty B)
- Could affect enrollment of dependents on an employer sponsored health plan

Inflation Reduction Act

Inflation Reduction Act

Medicare Prescription Drug Costs

- 2024 – Eliminates 5% co-insurance on Medicare catastrophic drug coverage
- 2025 – Medicare $2,000 Rx out-of-pocket cap
- 2026 - Medicare to negotiate Rx price
  - Targeting 10 high-spending drugs that are older and not facing generic competition
    - More drugs added in later years
  - Minimum price reduction of 25% - up to 60% if drug has been on market for a long time
  - If drug companies don't agree to the negotiated price they may face financial penalties of 65% - 95% of drug sales to Medicare

Expanded Premium Tax Credits

- Allows individuals with household income under 150% federal poverty level (about $40,000 for a family of 4) to enroll in Marketplace coverage on a monthly basis through 2025

Consolidated Appropriations Act of 2023

Relief for HSAs and Telemedicine

HSAs and Telemedicine

Background IRS Rule

- HDHPs that pay for non-preventive services before the deductible is met will lose HSA eligibility
- Telemedicine fees less than fair market value (FMV) of the visit will cause a plan participant with an HDHP to be ineligible for an HSA

Previous Relief

- In 2020, the CARES Act granted relief from the FMV rule under the end of 2021
- The relief was extended again in 2022 from April 1, 2022-December 31, 2022

2023 Extended Relief

- The CAA 2023 extends relief from the FMV requirement starting January 1, 2023, for another two years
- Relief is based on the plan year which means a gap in relief for mid-year renewals
- Like previous relief the relief is permitted and not required

Other Considerations

Public Health Emergency Extended
National Emergency Outbreak Period Still Effective
Section 1557 and Non-Discrimination in Health Care
Dobbs v. Jackson Women's Health

National Emergency & Public Health Emergency

National Emergency

- In 2020, certain ERISA, COBRA, and HIPAA deadlines were extended for one year until 60 days following the end of the "outbreak period" or the end of the National Emergency whichever came first
- Deadlines were extended again in 2021 and 2022
- These extensions remain in place and toll based on the individual deadlines triggered by the qualifying event

Public Health Emergency

- Starting in 2020 as part of the COVID-19 public health emergency costs for COVID-19 tests and vaccines must be covered by health plans at no cost-sharing
- The public health emergency has been renewed several times since 2020 and remains in effect

Section 1557 & Non-Discrimination in Health Care

Section 1557

- "Covered entities" are required to comply
- Cannot deny or limit coverage or impose additional cost-sharing in health insurance and other health-related coverage based on race, color, national origin, sex, age, or disability.

Bostock v. Clayton County (2020)

- Title VII protection against employment discrimination based on sex extends to discrimination based on an individual's sexual orientation or gender identity
- Currently there is no specific guidance as to exactly what type of coverage must be available, BUT some federal courts ruled in favor of individual claims of discrimination for failure to provide equal or medically necessary coverage related to gender identity or gender dysphoria
  - *Kadel v. Folwell*
  - *Lange v. Houston Cnty*

Next Steps for Plan Sponsors

- Be prepared to remove categorical exclusions and review limitations on coverage

Dobbs v. Jackson Women's Health

Background

- On June 24th, 2022, the Supreme Court released its final decision in *Dobbs v. Jackson Women's Health Organization (Dobbs),* overturning precedent case law from *Roe v. Wade* and *Planned Parenthood v. Casey*
  - Overturning *Roe* returns the legality of abortion to the states
  - Several states already have already banned or restricted abortion
  - Some states impose "aid and abet" laws

Impact on Employer Health Plans

- The *Dobbs* decision does not have a direct affect on employer health plans
  - Fully insured health plans will need to follow state laws and may not cover abortions in locations where it is prohibited by state law
  - Self-funded health plans, are not subject to state insurance laws due to ERISA preemption, but are subject to state criminal and similar laws
    - Generally speaking, ERISA will not preempt a criminal law

Dobbs v. Jackson Women's Health

Employer Considerations

- Options for providing coverage for abortion services
  - Cover under the plan in states where abortion is legal
  - Spending accounts (HSA, FSA, HRA)
  - EAPs
  - Travel benefit
  - Lifestyle account
- Mental health parity issues
- State aid and abet laws

Next Steps for Employers

- Determine level of risk and appetite for change if necessary
- Discuss decisions with legal counsel

Questions?