2022

Employee Benefits Legislative & Regulatory Update

Presented by Benefit Comply

- Welcome! We will begin at 3 p.m. Eastern
- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.
- You will be able to submit questions during the webinar by using the “Questions” or “Chat” box located on your webinar control panel.
- Slides can be printed from the webinar control panel – expand the “Handouts” section and click the file to download.

Bob Radecki, Senior Regulatory and Public Policy Analyst
Bob Radecki has over 30 years of experience in the HR and employee benefits industry helping employers deal with difficult benefit and compliance matters. Previously Mr. Radecki founded, and served as President of A.E. Roberts Company, a nationally recognized compliance consulting and training firm. Bob is recognized as a leading expert on a variety of benefit compliance issues including COBRA, FMLA, ERISA and Health Reform. Bob has been the featured speaker at many industry events and conferences and has published several articles concerning employee benefits compliance issues.

Delaney Callahan J.D. Senior Consultant
Prior to her current position Delaney worked in the third-party administrator field where she researched and assisted in maintaining compliance with Section 125 regulations and COBRA, ERISA, and ACA requirements for health and welfare benefit plans of a wide range of employers. As a Senior Compliance Consultant at Benefit Comply, she provides guidance on regulatory compliance for health and welfare benefit plans to insurance professionals and directly to employers. Ms. Callahan received her law degree from Michigan State University College of Law and her bachelor's degree from Calvin College.

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- RCM&D
- The Rowley Agency
- Starkweather & Shepley
- Sterling Seacrest Pritchard
- Woodruff Sawyer

Agenda

- Regulatory and Legislative Update
  - Surprise Billing Update and Court Case
  - Plan coverage of OTC COVID tests
  - §4980H Affordability % Change
  - National Emergency Extension
  - Telemedicine and HSA Eligibility
  - Employer Reporting Changes
  - Health Plan Cost Transparency Data Release
  - Continuity of Care Requirements
  - Rx Cost Reporting
  - Other 2022 Issues
- Employer Vaccine Strategies after SCOTUS Mandate Ruling

Regulatory and Legislative Update

Surprise Billing

- Types of Medical Service and Claims Affected
  - Out-of-Network Emergency Services
    - Addresses the “rent an emergency Doc” problem
  - Air Ambulance
  - Out-of-Network Providers in an In-Network Facility (Anesthesiologists, Radiologists, Etc.)
- Payers' payment to OON provider will initially be based on:
  - State all-payer database or other state balance billing laws
  - “Qualified Payment Amount” (QPT) = Median of the payer’s contracted rates for that particular service
- Balance Billing Protection
  - The member cost share will be calculated as if service was provided in-network and provider is prohibited from balance billing the individual

Surprise Billing

- Payment Dispute Resolution
  - If OON providers refuses payers “offer” it goes to an Independent Dispute Resolution (IDR) process
    - Payer submits $ offer – Provider submits $ offer – Arbiter chooses one
      - Rule requires that IDR arbitrator select the proposed payment amount closest to the QPA unless certain conditions are met
    - Provider cannot balance bill the patient
- Recent Court Case
  - Providers did not like that the QPA was used to “steer” the arbiter toward the QPA
  - Federal court struck down just part of the regulations related to the IDR process

Impact of the Courts Decision:

1. Full surprise billing protections still in place.
2. May increase disputes that go to arbitration and result in more variability in final costs decided by arbiter

Health Plan Payment for OTC Covid Tests

- All Health Plans Must Cover OTC Covid Tests Starting 01/15/22
  - Any FDA approved test covered 100% - No copay or OOP for participant
    - Applies to grandfathered plans
  - Participant can submit claim for reimbursement
    - Plan can require normal substantiation
  - Maximum of 8 tests (4 two-test boxes) per month per participant
    - Family of 4 could get 32 tests (16 2-test boxes)
  - Plan can impose maximum reimbursement rate of $12 per test only if it meets the direct pay safe-harbor

Health Plan Payment for OTC Covid Tests

- Direct Pay In-Network Safe-Harbor
  - To limit reimbursement rate per test - carrier or plan must implement a direct pay “in-network” process so participant does not have to submit claim for reimbursement
    - Reimbursement for out-ot-network tests can be limited to $12 per test ($24 per 2-test box)
  - Plan must offer both direct pay retail sites AND a home delivery option (mail, phone or web based)

- Plans Do NOT Have to Reimburse Tests for Employment Purposes
  - Can require attestation from participant

§4980H "Affordability" % Change

- Affordability % Change
  - In Revenue Procedure 2021-36, the IRS decreased the affordability percentage from 9.83% to 9.61% for 2022
    - Effective for plan years beginning on or after January 1, 2022

Affordability Percentage	2015	2016	2017	2018	2019	2020	2021	2022
	9.56%	9.66%	9.69%	9.56%	9.86%	9.78%	9.83%	9.61%

    - The decrease in the affordability percentage may require employers to lower employee contributions for the 2022 plan year to meet the affordability requirements under §4980H(b)
  - W-2 Safe Harbor Example

	2021	2022
W-2 Salary	$25,000.00	$25,000.00
	9.83%	9.61%
	$2,457.50	$2,402.50
Affordable Monthly Employee Contribution	**$204.79**	**$200.20**

Build Back Better Proposed Legislation

- Health Insurance Related Provisions
  - Changes employer-sponsored coverage affordability test to 8.5% of household income with no indexing (9.61% in 2022)
    - Indexing begins again in 2027 plan year
    - Would apply to both premium tax credit eligibility and employer mandate
    - Would make employer plans “unaffordable” more often

	2021	2022	Proposed
W-2 Salary	$25,000.00	$25,000.00	$25,000.00
	9.83%	9.61%	8.50%
	$2,457.50	$2,402.50	$2,125.00
Affordable Monthly Employee Contribution	**$204.79**	**$200.21**	**$177.08**

Public Health Emergency & National Emergency

- On February 18, 2022, President Biden formally extended the COVID-19 National Emergency
- There are two different kinds of pandemic related “Emergencies”

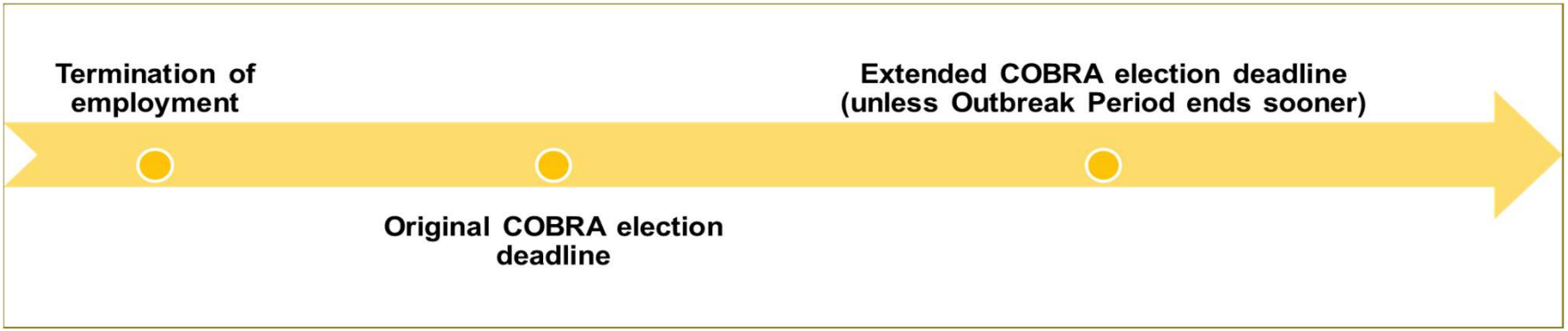
Public Health Emergency	National Emergency
Declared by Department of Health and Human Services (HHS) beginning in January 2020 and extended multiple times - Each extension lasts three months.	First declared by President Trump in March 2020 - Remains in force until declared over by President. “Outbreak Period” = End of National Emergency + 60 days.
Group health plans required to cover COVID-19 diagnostic testing and vaccinations and related services, including out-of-network	COBRA notice, HIPAA special enrollment notice, and ERISA claims filing deadlines are all delayed for one year from the original deadline applicable to any participant or until the end of the outbreak period (TBD)

National Emergency and Outbreak Period

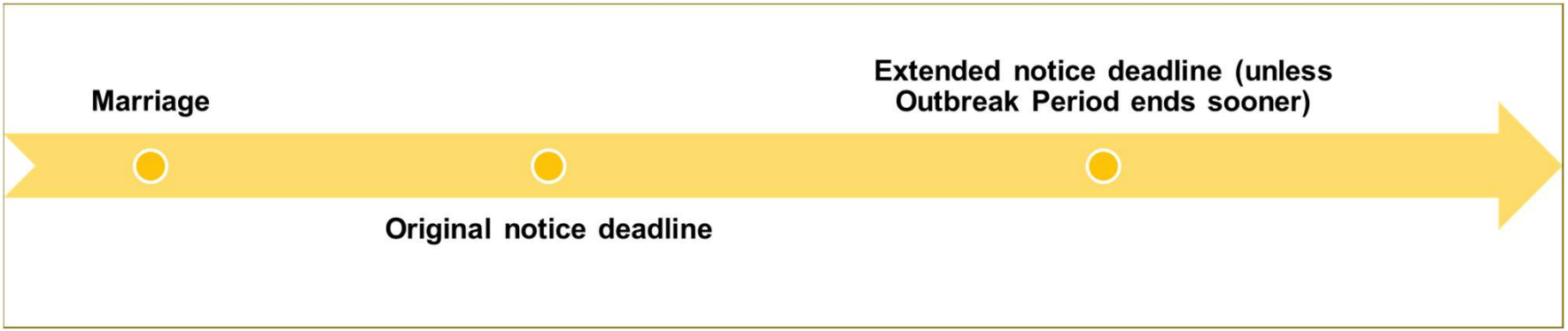
- COBRA notice, HIPAA special enrollment notice, and ERISA claims filing deadlines are delayed for one year (the “disregarded period) or until the end of the outbreak period (TBD)
- Disregarded Period
  - Outbreak Period (National Emergency + 60 days) or 1 year from the individual’s original deadline (whichever expires first)
  - Applies to the following deadlines:
    - Notice for requesting HIPAA special enrollment rights
    - ERISA claims filing deadlines (including health FSA and HRA run-out periods)
    - COBRA elections and payments

National Emergency and Outbreak Period

- Example – COBRA Election



- Example – HIPAA Special Enrollment Right



Telemedicine and HSA Eligibility

- HSA Eligibility Review
  - To be eligible to make or receive HSA contributions
  - Must be Covered by an HDHP
    - For 2022 the minimum deductible for an HDHP is $1,400 single and $2,800 for a family coverage
  - HSA contribution eligibility is determined on a month-by-month basis for the calendar year
    - If participant is ineligible for just part of the calendar year the maximum annual HSA contribution is reduced
  - Cannot have “Disqualifying Coverage” – Examples:
    - Non-HDHP health plan
    - Full Health FSA
    - Medicare
    - Telemedicine benefits with first dollar coverage or care that costs less than fair market value before participant has met the minimum HDHP deductible

Telemedicine and HSA Eligibility

- Cares Act Telemedicine HSA Eligibility Relief
  - Beginning in March 2020 - Employers allowed to offer telemedicine with coverage before participants have met the applicable minimum deductible, without jeopardizing the employee's eligibility to make HSA contributions
  - This HSA safe harbor expired for plan years beginning 1/1/2022
- New Relief in Consolidated Appropriations Act 2022 signed March 15, 2022

Telemedicine coverage will again be temporarily disregarded for purposes of HSA eligibility from April 1, 2022 through December 31, 2022.

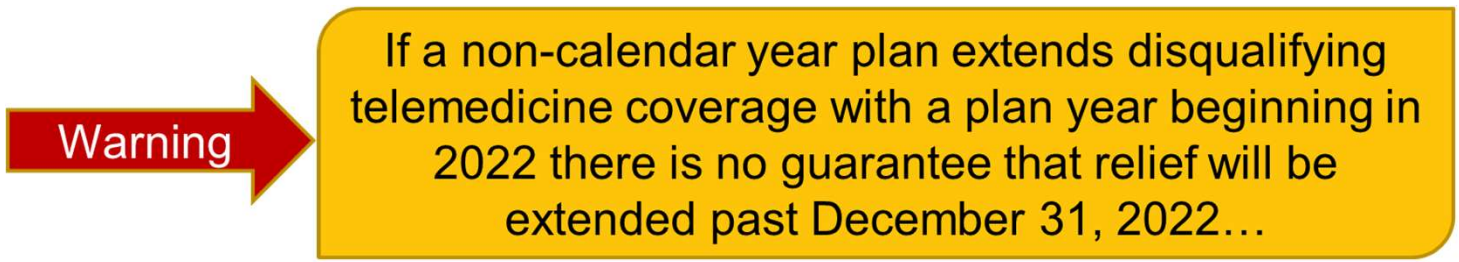
Telemedicine and HSA Eligibility

- Calendar Year Plans Beginning 01/01/22
  - If a participant is otherwise HSA eligible but has disqualifying telemedicine coverage
    - HSA ineligible from January - March then eligible from April - December of 2022
    - This means that a participant who is otherwise HSA eligible for all of 2022 can make a maximum HSA contribution of 9/12ths of normal HSA annual contribution.

2022 Maximum Annual Contribution:
• Single HDHP Coverage - $2737.50 ($3650 x 9/12) • Family HDHP Coverage - $5475.00 ($7300 x 9/12)

Telemedicine and HSA Eligibility

- Non-calendar Year Plans Beginning in 2021
  - Participants would have been HSA eligible through the end of the plan year based on old Cares Act relief
  - Now relief is available, but only to the end of 2022



Employer Reporting Changes

- End of Penalty Relief for Reporting Errors
  - In previous years the IRS had provided penalty relief for reporting errors
    - This relief was only available if the employer filed timely and could show it made good faith efforts to comply with information reporting requirements
    - IRS has already been imposing penalties for late filing
  - The IRS makes it clear in the proposed rules that this “good faith relief” is no longer available beginning with reporting for the 2021 calendar year
    - Penalties of up to $280 per form for inaccurate Form 1095 provided to participants
    - Separate $280 per form penalty could be applied for the same mistake in the forms filed with the IRS, potentially triggering a penalty of up to $560 per employee
  - Employers should carefully review 1095s before submitting to IRS and providing to participants

Health Plan Cost Transparency Data Release

- Pricing Data Disclosure
  - Effective beginning in July 2022 - Plans and insurers must publicly post machine-readable data files
    - The In-Network Rate File
      - All applicable rates with in-network providers for all covered items and services (including negotiated rates, underlying fee schedules, or derived amounts)
    - The Allowed Amount File
      - One on billed charges and allowed amounts for covered items and services provided by out-of-network providers
  - This information must be updated monthly and made publicly available on carrier's or plan's website free of charge
    - Full-insured plans can contract with a carrier to post required data
      - Rules make it clear that carrier is in violation if rules are not followed
    - Self-insured plans can contract with TPA or other vendor to post files
      - Rules are clear that plan sponsor (employer) is liable if rules are not followed
  - *Note – A prescription drug file requirement is delayed until further notice

Continuity of Care Requirements

- When a provider leaves a network a “continuing care patient” can request continued transitional care covered by the plan on an in-network basis for up to 90 days
  - Effective for plan years beginning on or after January 1, 2022
  - Notice Requirement
    - The plan must notify each “continuing care patient” at the time of a termination affecting a provider or facility of the right to elect continued transitional care from the provider or facility
    - Notice must explain how the individual can elect to continue to have benefits provided under the same terms and conditions as would have applied in-network
  - A continuing care patient is defined as with respect to a provider or facility if the individual
    - is undergoing a course of treatment for a “serious and complex condition”
    - is undergoing a course of institutional or inpatient care
    - is scheduled to undergo nonelective surgery from the provider
    - is pregnant and undergoing a course of treatment for the pregnancy
    - is or was determined to be “terminally ill”

Rx Cost Reporting

- Detailed Rx and Cost Data Must be Reported Annually
  - Who? - Employer Plan Sponsors and Carriers
  - When? - Effective beginning December 27, 2022
- What Must be Reported?
  - Rx spending by plan and participant
  - Number of enrollees
  - Total spending by the plan by types of cost (e.g., hospital, primary care, specialty care, provider and clinical service costs, prescription drugs, wellness)
  - 50 most common prescription drugs paid by the plan & total claims paid for each drug
  - 50 most costly drugs & the annual amount spent for each of the 50 drugs
  - 50 drugs with the greatest year-over-year cost increase
  - Average monthly premiums paid by the employer and the participants
  - And more...

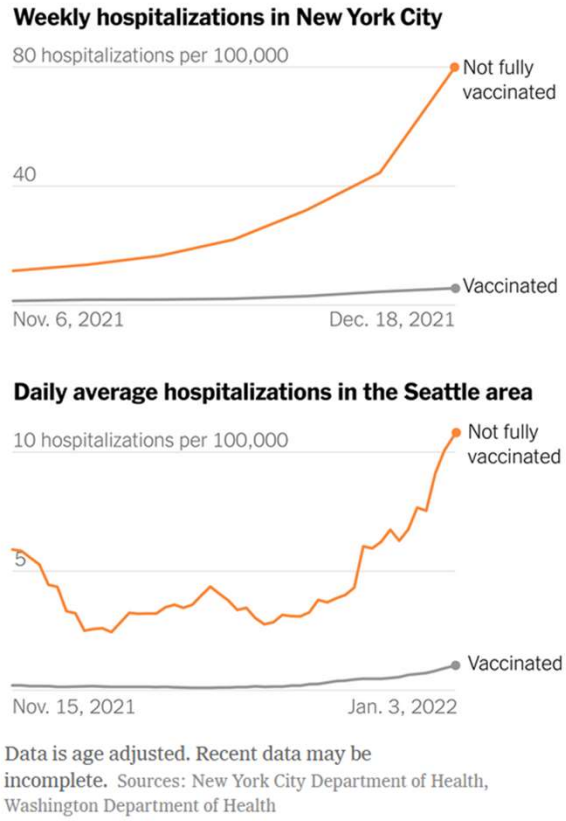
Other 2022 Issues

- No Gag Clause in Provider Contracts
  - Effective December 27, 2020
- ID Card Requirements
  - ID cards must include deductible and out-of-pocket maximum amounts
  - Effective for plan years beginning January 1, 2022
  - Carriers and plans can make good faith attempt to comply until additional guidance is released
- Provider Directory Accuracy
  - If an individual receives services from an out-of-network provider and relied on inaccurate provider directory information, the plan must play the claim as if it was provided in network
  - Effective for plan years beginning January 1, 2022

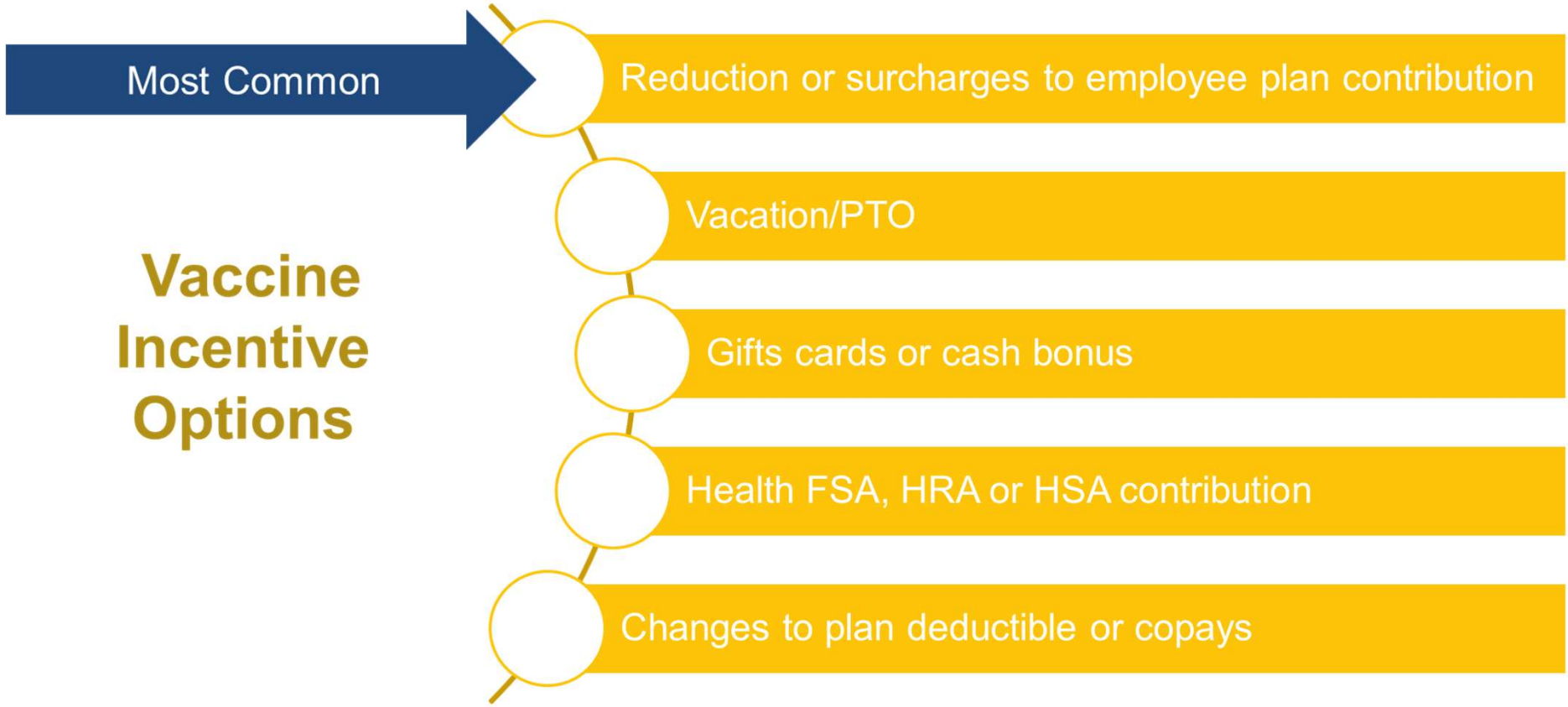
Employer Vaccine Strategies after SCOTUS Ruling

Vaccination Incentives and Surcharges

- Will employer's interest in incentives increase with mandates off the table?
  - If as some predict COVID will be with us for long time, will employers use incentives as a long-term strategy?
  - What about increased claims cost to the plan for unvaccinated employees?
  - Will vaccine surcharges become a regular plan cost containment strategy like smoker surcharges have become with some employers?



What Incentive Strategies are Employers Using?



Vaccination Incentives and Surcharges

- HIPAA Wellness Rules - Vaccine incentive is a health-contingent wellness program
  - Must offer a reasonable alternative standard or waive the requirement for those who cannot participate due to health status
  - Must limit incentive (or penalty) to no more than 30% of cost of health coverage
    - If employer requires spouse to be vaccinated the incentive can be up to 30% of family premium
    - Limit includes all health-contingent wellness incentives provided by employer

Remember tobacco related incentives can be up to 50% of plan premium so employer could impose a 30% vaccine surcharge plus a 20% tobacco surcharge.

  - EEOC Wellness Rules - EEOC ruled that just asking for proof of vaccination does not trigger EEOC wellness rules

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