Employee Benefits Regulatory Update

Compliance Series

Nov. 11, 2021

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Presenters

Liz Mann, J.D.
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 12 years of experience working in employee benefits and offers expertise in ERISA, IRS, COBRA, FMLA and ACA compliance.

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.

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Agenda

- Recent Regulatory Guidance
- Pandemic Related Benefits Rules
- 2022 Health Cost Transparency Rules and Surprise Billing Protections
- Benefits Changes Contained in the Reconciliation Bill
- Vaccine Incentives and Preview of Upcoming Vaccine Mandate Webinar

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PANDEMIC RELATED BENEFITS RULES

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IRS Plan Limits

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- Revenue Procedure 2021-45 (released 11/10/21)
  - Health FSA Contribution Limit
    - Increased to $2,850 for plan years beginning in 2022
    - Carryover increased to $570
  - Qualified transportation and parking benefits
    - Limit on monthly contributions increased to $280 in 2022

- 2022 HSA Limits (announced earlier this year)
  - Maximum Contribution
    - Self-only = $3,650, Family = $7,300
  - HDHP Minimum Deductible
    - Self-only = $1,400, Family = $2,800 (unchanged from 2021)
  - HDHP Maximum OOP
    - Self-only = $7,050, Family = $14,100

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Public Health Emergency & National Emergency

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- Remember 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.	Declared by President Trump in March 2020 - Remains in force until declared over by President. "Outbreak Period" = End of National Emergency + 60 days.

- Public Health Emergency - Impact on Benefit Plans
  - Group health plans required to cover COVID-19 diagnostic testing and vaccinations and related services, including out-of-network
  - Plans not required to cover COVID-19 testing for employment purposes
- National Emergency - Impact on Benefit Plans
  - 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)

Other

- Telemedicine and HSA Eligibility
  - IRS Notice 2020-29 allowed HDHP plans to cover telehealth services prior to participant meeting minimum deductible without making them ineligible to make HSA contributions
  - Relief was provided only for plans beginning on or before 12/31/21
  - To maintain HSA eligibility - Effective plan years beginning 1/1/22, telehealth benefits can only pay for preventive services until the participant has met the minimum HSA deductible

§125 and §129 Flexibility Expiring

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- Temporary, Optional, Cafeteria Plan Flexibility offered for plan years ending in 2020 or 2021
  - Expanded carryovers or grace periods
    - HFSA and DCAP plans could offer a carryover of all unused amounts OR up to a 12-month grace period
  - Health FSA post termination reimbursements
  - Election change flexibility
- Plan Amendments
  - May retroactively implement any provisions so long as the employer informs all eligible employees of changes
  - Formal plan amendments must be made by last day of the first calendar year after plan year in which change is effective
- Annual Increase in DCAP contribution limit Going Back to $5,000 in 2022
    - Temporary maximum DCAP pre-tax payroll deduction of $10,500 ends in 2021
    - Carryover amounts from 2021 will not count toward the 2022 maximum

2022 HEALTH COST TRANSPARENCY AND SURPRISE BILLING ISSUES

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Summary of Timing

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- 2021
  - Hospital Cost Reporting – January 2021
- 2022
  - Carriers and TPA Release Health Plan Data Files - July 2022
  - ID card and Provider Directory Accuracy – January 2022
  - Surprise Billing rules and balance billing protection – Plan years starting January 1, 2022
- 2023
  - Payers must release price transparency tools - 500 items & services January 2023 - all items and services January 2024
- Enforcement Delayed Until Further Notice
  - RX Cost Reporting ~~eff. beginning Dec. 27, 2021~~ -
  - Provider Good Faith Estimate ~~January 2021~~ –CAA Good Faith Estimate "Advanced EOB" -Effective ~~January 2022~~

Hospital Cost Reporting

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- Requirement Basics – Effective 1/1/2021
  - Hospitals must publish a machine-readable file containing these types of charges for all "items and services" provided by the hospital
    - Gross charges - The non-discounted rate, as reflected in a hospital's chargemaster
    - Discounted cash prices - The rate the hospital would charge individuals who pay cash
    - Payer-specific negotiated charges - The rate that a hospital has negotiated with a third-party payer
    - De-identified minimum negotiated rates - The lowest rates that a hospital has negotiated with all third-party payers without identifying the payer
    - De-identified maximum negotiated rates - The highest rates that a hospital has negotiated with all third-party payers without identifying the payer
  - Hospitals must publish a more consumer friendly list for the hospital's 300 most "shoppable services,"
    - CMS listed 70 shoppable services that must be included; up to the hospital to select the remaining 230

Health Plan Cost Transparency and Disclosure

- Pricing Data Disclosure
  - Effective beginning in ~~January 2022~~ July 2022 - Plans and insurers must publicly post three machine-readable 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
    - The Prescription Drug File - Enforcement delayed indefinitely
      - Negotiated rates and historical net prices for prescription drugs furnished by in-network providers
  - This information must be updated monthly and made publicly available on carrier's or plan's website free of charge

Surprise Billing

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- Effective for Plan Years beginning January 1, 2022
- 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
  - Other state balance billing laws (self-insured plans can opt-into state laws)
  - "Qualified Payment Amount" (QPA)
    - = 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

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- 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!
- Notices
  - General Notice
    - Posted on Payers Website
      - Model Notice available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act
    - In all EOBs
  - State "Opt-in Notice"
    - For self-insured plans that that opt-in to more restrictive state balance billing rules.
  - Other notices that will be responsibility of the payer
    - General notice on EOB, notice of payment details to OON providers

Surprise Billing

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- Most of the Responsibility Falls on Carriers and Administrators
  - Employers typically do not process the claims
    - Fully-insured plans carrier principally responsible for compliance
    - Self-insured plans - The plan sponsor/employer is technically responsible to assure that their plan is in compliance
      - Focus on TPA contracting and due diligence

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Build Back Better Proposed Legislation

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- 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
- Expanded Premium Tax Credits
  - American Rescue Plan Act increased subsidies for 2021 and 2022 for household incomes between 100 - 400% of the federal poverty level (FPL) & provides tax credits for taxpayers with household incomes above 400% of the FPL
  - Proposed legislation extends these subsidies through 2025

Significant Increase in Subsidies

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Table 1: Percent of Income Paid for Marketplace Benchmark Silver Premium, by Income		
Income (% of poverty)	**Affordable Care Act** (before legislative change)	**COVID-19 Relief (current law 2021-2022)**
Under 100%	Not eligible for subsidies*	Not eligible for subsidies**
100% – 138%	2.07%	0.0%
138% – 150%	3.10% – 4.14%	0.0%
150% – 200%	4.14% – 6.52%	0.0% – 2.0%
200% – 250%	6.52% – 8.33%	2.0% – 4.0%
250% – 300%	8.33% – 9.83%	4.0% – 6.0%
300% – 400%	9.83%	6.0% – 8.5%
Over 400%	Not eligible for subsidies	8.5%

Source: Kaiser Family Foundation

Significant Increase in Subsidies

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- Silver Plan Cost (Approx. a $3,000 deductible plan – but OOP reduced for lower income)
- Remember employee's who are offered "affordable" coverage by their employer are not eligible for subsidies

Annual Household Income	Family Size	% FPL	Average "Retail" Monthly Prem.	Subsidized Silver Plan Monthly Prem.
$20,000	1	157%	$353	$5
$20,000	4	76%	Medicaid	Medicaid
$40,000	1	313%	$353	$211
$40,000	4	153%	$1,245	$4
$60,000	1	470%	$353	$353
$60,000	4	229%	$1,245	$158
$80,000	4	305%	$1,245	$409
$125,000	4	477%	$1,245	$885

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Vaccination Incentives and Surcharges

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- Mandate vs. Incentive
  - Will employers still want to consider incentives even after mandate is in place?
    - Mandate will have the weekly testing opt-out option – employers may still want to offer incentives to some
    - What about employers <100 employees
  - OSHA's emergency temporary status declaration will only be for 6 months
  - If as some predict COVID will be with us to some extent of time, will employers use incentives as a long-term strategy?
  - Could legal challenges to Biden mandate delay implementation?

What other incentive strategies are employers using?

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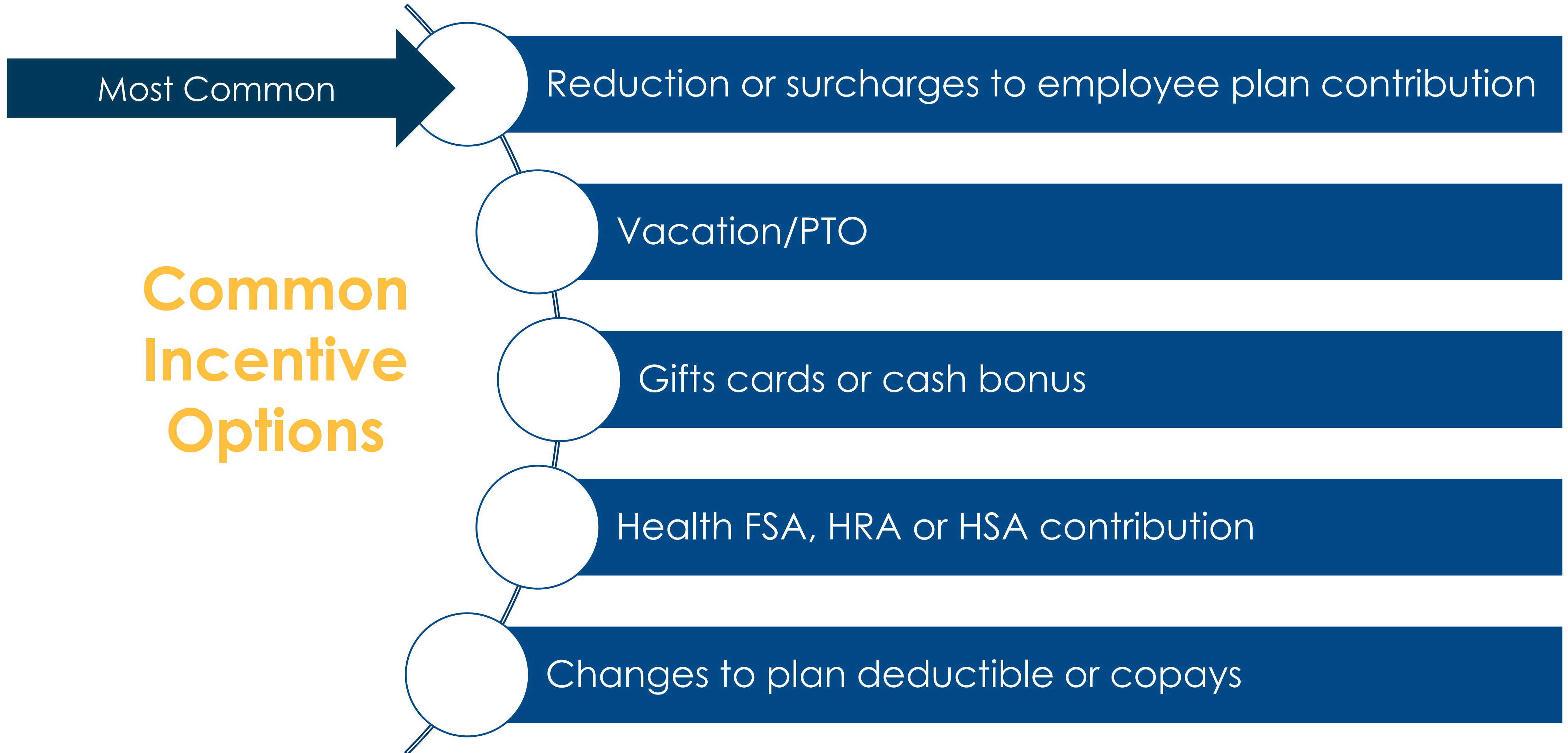

Vaccination Incentives and Surcharges

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- HIPAA Wellness Rules
  - Health Plan contribution discounts or surcharges
  - Benefit adjustments (e.g. waiving co-pays)
- Obtaining a vaccine is a health-contingent wellness program
  - Must provide annual opportunity to earn the incentive (avoid the penalty)
  - Must offer a reasonable alternative standard or waive the requirement for those who cannot participate due to health status
    - Must provide notice of the availability of a reasonable alternative standard
  - Must limit incentive (or penalty) to no more than 30% of cost of health coverage
    - Limit includes all health-contingent wellness incentives provided by employer
- EEOC Wellness Rules - Apply only to wellness programs where employer asks medical questions or does medical testing
  - EEOC ruled that just asking for proof of vaccination does not trigger EEOC wellness rules

EPIC Vaccine Mandate Webinar

EPIC Special Webinar

Answers to Your Questions About OSHA's Vaccination Mandate ETS

Thursday, November 18, 2021
2:00 to 3:00 PM ET

REGISTER at: https://epicbrokers.com/insights/2021-epic-employee-benefits-compliance-webinar-series/

The Occupational Safety and Health Administration (OSHA) has issued an Emergency Temporary Standard (ETS) mandating large employers to have a policy requiring employees to be vaccinated or be subject to weekly COVID-19 testing.

While the rules are being challenged in court, the timeframe for rules to go into effect is short and employers must begin to implement their strategy now.

We'll answer questions like, "Which employees are exempt from the requirement? What must be included in the employer's written policy? What kind of tests are allowed for employees choosing not to receive the vaccine? Who pays for the tests? Can employers mandate vaccinations with no option for testing?"

Join leading compliance experts Michael Goldfarb J.D., President of Guardian HR, and Bob Radecki, Senior Regulatory and Public Policy Advisor at Benefit Comply, LLC, to answer these questions and more.

Questions?

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