ALSTON & BIRD

HEALTH & WELFARE PLAN LUNCH GROUP

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- Additional Items to Note

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LEGISLATIVE UPDATE

Health Care Related Provisions in the Build Back Better Act *

*Nov. 5 version to be considered on House floor (likely week of Nov. 15)

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House Process for Build Back Better Act (HR 5376) (a long and winding road)

- Oct. 7, HW Update – reviewed the Ways and Means provisions included in the Budget Committee bill (which combined the provisions approved by the various House Committees)
- Oct. 28 – House rules committee released a revised version of BBB
  - Big picture, this draft substantially trimmed the scope of the package and significantly modified certain tax revenue raisers, including eliminating "pure" corporate and individual rate increases.
- Nov. 3 – House rules committee released another revised version
- Nov. 5 – House rules committee released a short amendment to the Nov. 3 version
  - The Nov. 3 version, with the Nov. 5 amendment is set to be considered by the House

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Still in: DOL MHPAEA Civil Penalty

- Allows DOL to impose a civil penalty for MHPAEA violations
- $100 per day per each impacted participant or beneficiary
- Can be imposed directly on insurers, as well as on plan sponsors and administrators
- Subject to the same waivers for reasonable cause and certain minimums/maximums as present-law civil penalties relating to use of genetic information
- Effective beginning 1 year after DOE

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Still in: Increase in employer pay-or-play affordability standard

- Changes how affordability is determined for employer pay-or-play penalties
- Reduces threshold to 8.5% for 2022 through 2025
  - Threshold for 2021 is 9.83%
- Threshold is not indexed
- Also includes expansions of the premium tax credit

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Still in: Bicycle commuting fringe benefit

- Effective starting in 2022, reinstates and expands the section 132 bicycle commuting benefit
- Monthly benefit is 30% of the maximum allowable qualified parking benefit
  - For 2021, qualified parking benefit is $270/mo; 30% of $270 is $81/mo
- Applies with respect to bicycles, electric bicycles (within the meaning of the new electric bike credit included in the bill), non-motorized 2- or 3-wheeled scooters, and any 2- or 3-wheeled scooter propelled by an electric motor if such motor does not provide assistance in excess of 20 miles per hour.

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New: Cost-sharing requirements for insulin (amends ERISA, PHSA, Code)

- Group health plans must cover at least one of each dosage form of each different type of insulin
  - Examples of dosage form: vial, pump, or inhaler
  - Examples of different types of insulin: rapid-acting, short-acting, intermediate acting, long-acting, ultra long-acing and premixed)
- Cannot apply any deductible
  - HSA interaction
- Cost sharing (for a 30-day supply) is limited to lesser of: $35 or 25% of the negotiated price under the plan
- Effective for plan years beginning on/after Jan. 1, 2023

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New: Reporting for PBMs (amends ERISA, PHSA, Code)

- PBMs and insurers must provide detailed reports to plan sponsors including information regarding the administration of prescription drug benefits by PBMs and detailed information regarding rebates, fees, and other compensation.
- Reports must be provided every six months and must be in machine-readable format.
- Contracts that limit the disclosure of information to plan sponsors in such a manner that prevents the making of required reports are prohibited.
- Effective for plan years beginning on/after Jan. 1, 2023.

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Back in with modifications: Rx Pricing

- **Drug Price Negotiation (fewer drugs, only applies to Medicare)**
  - Starting in 2025, HHS to negotiate prices for certain single source drugs that lack price competition
  - HHS to identity 100 drugs for possible price negotiation
  - HHS to negotiate prices for up to 10 drugs in 2025, 15 in 2026 and 2027, and 20 thereafter
  - ***Negotiated prices apply only to Medicare, not to private sector plans***
- **Inflation Rebates**
  - Requires drug manufacturers to pay a rebate to the federal government if prices increase faster than inflation
  - The amount of the rebate takes into account not only drugs provided through Medicare, but also **group health plans** and commercial market generally

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Back in with modifications - Federal Paid Family and Medical Leave Program

- Creates a federally administered paid leave program funded by general federal revenues; not an employer mandate
- Up to 4 weeks of paid leave in a 12-month period for various reasons, including sickness and caregiving
- "Legacy" states that already have leave programs may receive a grant for the cost of the leave from the federal government
  - States may share the grant with employers that provide leave programs under state law.
- For employers that maintain their own leave programs:
  - Grants for up to 90% of the cost of leave if the employer's plan provides leave comparable to the federal paid leave program, for all eligible employees
    - Applies to leave provided through insurance, through a multiemployer plan or by the employer on a self-funded basis
- Does not preempt state leave laws -- states may adopt new laws, but will not receive federal grant money

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NOT in: Telehealth HDHP extension (has not been in any draft)

- CARES Act allows HSA eligible HDHPs to cover telehealth without cost-sharing
- Applies for plan years beginning on or before Dec. 31, 2021
- As yet, an extension is not included

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NOT in: Extension of ARPA increase in DCAP limit

- Ways and Means/Budget Committee version included a permanent extension of the ARPA provision that increased the DCAP limit to $10,000 ($5,000 for married filing separately)
- Was dropped in the Oct. 28 Rules Committee version, and remains out at this point

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Next steps in the process….

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Preparing for 2022: No Surprises Act

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Preparing for 2022: staying out of the pit

- Identify new requirements
- Identify old requirements coming to an end
- Plan sponsors and vendors must coordinate and cooperate to comply

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What are the new group health plan provisions for 2022?

- Consolidated Appropriations Act (CAA)
  - Title I-No Surprises Act
    - Balance billing protections for emergency services, certain non-emergency services, and air ambulance
    - Continuity of Care requirements
    - Provider directory requirements
    - Advance EOB and price comparison tools ("CAA Transparency")
    - ID Card information
    - Patient protections regarding primary care physician designations
  - Title II-Transparency
    - No gag clauses in service agreements
    - NQTL comparative analysis disclosure
    - Compensation disclosure for "brokerage" and "consulting" service providers
    - RX reporting
- Transparency Regulations ("Transparency Reg")
  - Machine readable disclosure of rates for in-network, out of network and RX allowed amounts ("Public Disclosure")
  - Price Comparison tool ("Individual Disclosure")

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To which plans do the new group health plan provisions apply?

- Division BB of CAA, Title I-No Surprises Act
  - Applies to both grandfathered and non-grandfathered plans
  - Does not apply to excepted benefits, HRAs and stand-alone retiree health plans
- Division BB of CAA, Title II-No Surprises Act
  - No Gag Order Provisions-Same as Title I
  - Brokerage/Consulting Services disclosure—All group health plans subject to ERISA
  - NQTL comparative analysis-does not apply to excepted benefits and stand-alone retiree health plans (only plans to which MHPAEA already applies)
  - Rx Reporting-same as Title I-No Surprises Act
- Transparency Reg
  - All non-grandfathered health plans
  - Does not apply to excepted benefits, HRAs and stand-alone retiree health plans

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When are the new group health plan provisions effective?

- Plan years beginning on or after January 1, 2022 with some exceptions
  - Gag order rules applied for contracts entered into after December 27, 2020
  - NQTL comparative analysis requirements went into effect February 10, 2021
  - Compensation disclosure rules for brokerage/consulting services effective for contracts executed on and after December 27, 2021
  - RX reporting begins December 27, 2021 (but see enforcement delay)
- Enforcement delays for some of the provisions (see later in presentation)

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Which provisions from 2020 and 2021 still apply in 2022?

- Outbreak period rules are still in effect!!!
  - Tolling period (i.e. the requirement to toll) will end for all events 60 days after end of National Emergency ("Outbreak Period End")
  - Each affected event—tolling period ends earlier of 1 year from start of tolling period or Outbreak Period End
  - Additional guidance
    - IRS Notice 2021-58
- COVID 19 Testing w/o cost share will remain in effect through the end of the Public Health Emergency
- Special COVID Vaccine Rules (e.g. No cost share for out of network services) through end of Public Health Emergency
- HDHP relief for COVID related services continues for PHE
  - But relief for free or low-cost telehealth does not apply to plan years that begin after December 31, 2021

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What rules are ending?

- Dependent Care FSA limit increase ends in 2021
- Special FSA relief from IRS 2021-15 ends for plan years ending in 2021
- HDHP relief for free or low-cost telehealth and remote care ends for plan years that begin after December 31, 2021

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2022 Key Highlights

- Grandfathered group health plans must comply with Title I, No Surprises Act provisions
  - Grandfathered plans did not have to comply with the ACA's emergency services rules or patient protections
- Emergency services rule is broader than under the ACA
  - Applies to out of network emergency services provided in independent free-standing clinics
  - Definition of emergency services is broader
    - Some out of network post stabilization services are considered "emergency services"
    - Emergency services not conditioned on whether otherwise covered by plan
  - "Greater of three" rule for calculating allowed amount is no longer effective (see Qualifying Payment Amount slides)
- Balance Billing protections also apply to:
  - Certain services provided by out of network provider at in-network facility
  - Air ambulance services

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2022 Key Highlights

- Balance billing protections have new term—Qualifying Payment Amount ("QPA")
  - Except where state law applies, QPA is the "allowed amount" for cost sharing calculation
  - QPA is the base for the Independent Dispute Resolution determination (if it goes to IDR)
  - THERE IS NO PRESCRIBED ALLOWED AMOUNT FOR PLAN TO PAY OUT OF NETWORK PROVIDER
    - "recognized charge" determined by plan
  - Self-insured plans may utilize the TPAs book of business to calculate the QPA

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2022 Key Highlights

- New external review requirements apply related to Balance Billing Protections
  - No Surprises Act expands external review to include whether a plan (or insurer) is complying with the "surprise billing and cost-sharing protections" under the NSA ("NSA External Review").
    - NSA External Review applies to grandfathered plans.
    - Grandfathered plans will need to arrange for an independent review organization (IRO).
- For insured plans, state external review is required to include these NSA provisions as well.
- Examples of when NSA External Review might apply:
  - Is it for emergency treatment (likely already covered)
  - Failure to treat non-participating at a participating facility as covered under the NSA provisions.
  - Whether an individual was medically/mentally capable to give informed consent to receive post-stabilization services at a non-participating facility after emergency services.
    - What happens if the plan determines the consent was not valid?
      - Reprocess as subject to NSA?
    - What happens if the dispute is instead over an alleged forged signature on the consent form or that the consent form was not provided separate from other documents?
      - IROs are not currently equipped to handle such disputes.

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2022 Key Highlights

- Disclosure of Balance Billing Protections required to be made available
  - Post on benefits plan website
  - Include with affected EOBs
  - May use model notice from DOL
- New IDR process will provide binding resolution process for out of network services subject to the Balance Billing Protections

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2022 Key Highlights

- Gag clause prohibition already effective (and has been for almost a year)
- DOL is actively requesting the NQTL comparative analysis and giving very little time to provide the information
- The brokerage/consulting services rules apply to ALL group health plans, including excepted benefits
  - Definition of "consulting" services appears to be broad
- Enforcement of some of the new group health plan rules has been delayed

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Enforcement Delays (group health plan provisions)

- Machine Readable Disclosure of Rates
  - Original 1/1/22 Deadline for providing machine readable IN rates extended to 7/1/22 for plan years starting 1/1/22 – 6/30/22
  - Original 1/1/22 Deadline for providing machine readable OON allowed amounts and billed charges extended to 7/1/22 for plan years starting 1/1/22 – 6/30/22
  - Original 1/1/22 Deadline for providing machine readable negotiated rated and historical net prices for prescription drugs extended indefinitely pending updated regulations

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Enforcement Delays (group health plan provisions)

- Price comparison tool under Transparency Regulations for 500 most common “shoppable” expenses originally due PY 1/1/23 (not extended but add phone number for questions)
- Price comparison tool for all covered expenses originally due PY 1/1/24 (not extended but add phone number for questions)
- Advance EOB originally due PY 1/1/22 delayed pending regulations pending regulatory price comparison tools

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Enforcement Delays (group health plan provisions)

- Advanced EOB: January 1, 2022 date extended indefinitely pending regulations.
- Prescription drug information and cost data originally due 12/27/21 and June 1, 2022 delayed until 12/27/22 and June 1, 2023

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Plan Sponsor Next Steps

- Claims administrators and sponsors should coordinate and cooperate to implement the new rules
  - Determine who will handle at IDR?
    - If service provider, what will fees be?
  - What will "recognized charge" be (i.e. the allowed amount used to calculate initial payment to provider)?
  - Determine who is handling the public and individual disclosures?
- Amend SPDs
  - Are SBCs affected?
- Post Balance Billing Protections Notice
- Amend contracting procedures to account for gag clause prohibition and brokerage/consulting compensation disclosures

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Next Steps For Insured Plans

- What steps must sponsors of insured plan take?
  - Group insurers are also generally subject to Group Health Plan requirements
  - Even if carrier is required to comply, sponsor can still be liable for compliance failures
  - Rules allow plans to contractually pass to insurance carrier the liability for failure to comply with Transparency Regs

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Additional Items to Note

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Vaccine/Testing Mandate

- Alston & Bird Labor and Employment/Health Care Advisory went out last Friday on the emergency temporary standard (ETS).
  - Outcome of Legal challenges?
- Either vaccine or testing for employers with 100 or more workers.
- ETS does ***NOT*** require employers to pay for testing but may be required by other laws, collective bargaining agreements etc.
- Neither the ETS nor other federal law requires ***a group health plan*** to cover testing conducted to screen for general workplace health and safety, public health surveillance, or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19.
- Federal law only requires group health plans to cover COVID-19 testing when such testing is medically appropriate for the individual, as determined by the individual's attending health provider.
- Employers may voluntarily pay for such tests; however, they should consider whether such payment creates an ERISA group health plan.
- If an employer had implemented a group health plan vaccination incentive or surcharge, is it still needed? Could it be rolled back for 2022?

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Lest we forget . . .

- Outbreak Period Issues continue
- CARES Act 3702 OTC and menstrual expense amendment (if required) for FSA plans
- End of CAREs Act Telehealth (and remote care) exception to HDHP deductible requirement
  - Some legislative proposals to extend
  - Note that IRS COVID relief for COVID expenses below HDHP deductible continues for PHE
- End of increased ($10,500) DCAP limits for CY 2021
  - Pay close attention to 55% testing
  - Will BBB Include extension ?
- Wind down of CAA COVID relief (carryovers, grace periods, unfettered FSA election changes)
- Deadlines for Required Amendments for FSAs for 2020 under COVID Relief
  - Dec 31st 2021 for 2020 amendments
  - For 2021, CAA 2021 allowed until end of CY that begins following PY for which amendment adopted

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2022 COLA Adjustments

BENEFIT	2021	2022
HSA contribution max (including employee and employer contributions)	$3,600 ($7,200 family) (Rev. Proc. 2020-32)	$3,650 ($7,300 family) (Rev. Proc. 2021-25)
HSA additional catch-up contributions	$1,000 (this is not indexed)	Same
HDHP annual deductible minimum	$1,400 ($2,800 family) (Rev. Proc. 2020-32)	Same (Rev. Proc. 2021-25)
Limit on HDHP OOP expenses	$7,000 ($14,000 family) (Rev. Proc. 2020-32)	$7,050 ($14,100 family) (Rev. Proc. 2021-25)
ACA limit on OOP expenses	$8,550 ($17,100 family)	$8,700 ($17,400 family)
Health FSA salary reduction max	$2,750	TBD
Health FSA carryover max	$550	TBD
Limit on amounts newly available under an Excepted Benefit HRA	$1,800	Same (Rev. Proc. 2021-25)
QSEHRA max reimbursement	$5,300 ($10,700 family)	(?)
Transit and parking benefits	$270 (monthly)	(?) (projected $280)
401(k) employee elective deferral max	$19,500 (Catch-up contributions $6,500)	$20,500 (Catch-up contributions $6,500)
Highly compensated employee	$130,000 (applies for 2022 plan year under look-back rule)	$135,000 (applies for 2023 plan year under look-back rule)
Key employee	$185,000	$200,000

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Thanks!

- Questions?