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HEALTH & WELFARE PLAN LUNCH GROUP

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One Atlantic Center
1201 W. Peachtree Street
Atlanta, GA 30309-3424
(404) 881-7885
E-mail: john.hickman@alston.com
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INDEX

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1

Agenda

- Is the ACA Constitutional?
- Impact/Status of Build Back Better Act
- Outbreak Period Update
- COBRA Subsidy Update
- CAA 2021 (Other than Surprise Billing)
  - Notice 2021-15: FSA and Election Change Relief
  - Compensation Disclosure, MHPAEA
- Agency Guidance on COVID Testing and Vaccinations
- Preparing for 2022: No Surprises Act
- Other Items of Note

2

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MONTHLY UPDATE

Supreme Court Addresses Constitutionality of the ACA. . . Again

- *California v. Texas (S. Ct. 2021)*
  - Background
    - June 2012: *Nat'l Fed'n of Indep. Bus. v. Sebelius* -- Supreme Court concludes that the so-called "individual mandate" is a tax for Constitutional purposes (but not a tax for other purposes). Held: ACA Constitutional
    - States challenged the constitutionality of the ACA following the legislative reduction of the individual mandate penalty to $0
    - Lower courts had agreed that the individual mandate was unconstitutional but disagreed as to whether only the mandate should be stricken or whether the entire ACA would be deemed unconstitutional
  - The Supreme Court decided the case on a procedural matter and held (7-2) that the plaintiffs challenging the ACA in the case did not have "standing" to sue—specifically that they had not suffered an injury
    - Court declined to address the constitutional issue regarding the individual mandate and the ACA
    - Lower court decisions were reversed and vacated, and the case was directed to be dismissed
  - In a nutshell . . .
    - The outcome means the ACA continues just as it always has

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Ongoing ACA Responsibilities

ACA Compliance "as usual" including . . .

- ACA Coverage Mandates
- ACA Patient Protections
- ACA Employer Responsibility Requirements
  - Note potential impact of BBB
- ACA Reporting
  - IRS proposed regulation effective for 2021 filings
    - Ends good faith relief
    - Permanently extends 1095B (insurers) and 1095C (self funded employers) deadline for INDIVIDUAL reports to March 2nd
    - Allows for alternate "posting" mechanism for 1095B and non-employee 1095C
  - Impact for state "mini-ACA" unclear – e.g., California, Massachusetts, New Jersey, Rhode Island, Vermont, and the District of Columbia

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LEGISLATIVE UPDATE

Health Care Related Provisions in the Build Back Better Act *

*As passed by the House on November 19, 2021

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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 date of enactment (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 for 2022 will be 9.61% under current law
  - Indexing of the 8.5% threshold will begin in 2027
- Issues for employers if this change is enacted with current effective date
- This change is related to provisions expanding access to the premium tax credit
  - The affordability standard for exchange coverage is similarly modified to 8.5%
  - Temporarily expands eligibility for premium tax credits to individuals are in non-Medicaid expansion states with income up to 138% of poverty level, even if they have access to affordable employer-sponsored coverage. There is no employer penalty in this case.

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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, 2024

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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 and timing….

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Outbreak Period Update

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Outbreak Period Guidance

- DOL issued guidance on 2/26/21 (Notice 2021-01) addressing the end of the Outbreak Period . . . . But first, a little history
- IRS/DOL jointly issued Notice 2020-01 in April of 2020.
  - HHS indicated "optional" for governmental plans
- The 2020 Notice prescribed a period that plans were required to disregard when determining due dates for certain enumerated actions.
  - HIPAA special enrollment
  - COBRA elections, premium payment, QB notices, and even election notices
  - Claims and appeals for all welfare and retirement plans subject to ERISA
  - External Review requests for non-grandfathered health plans subject to ACA
- This period of disregard is called the "Outbreak Period"
- The Outbreak Period began March 1 and ends the earlier of one year (Feb 28, 2021) or 60 days after the declared end of the National Emergency.

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Outbreak Period Guidance

- Joint notice stopped the counting during the Outbreak Period of any time frame that fell within the Outbreak Period.
  - E.g. If 45 days of your 60 day election period had occurred on March 1, 2020, then you would get 15 days to elect once the Outbreak Period ended.
  - E.g. If your COBRA election period fell entirely within the Outbreak Period, then you would get 60 days when the Outbreak Period ended.

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Outbreak Period Guidance

- Fast forward to February 2021.
  - National Emergency yet to be declared over —no end in foreseeable future
  - Nevertheless, did Outbreak Period end 2/28/21---1 year after it began on March 1, 2021?
  - DOL/IRS guidance said No.

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19

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2021 Outbreak Period Guidance

- Instead of applying the 1 year limitation to the Outbreak Period itself, the agencies applied it to the ***individual's affected time period***.
- An affected time period will have the applicable periods under the Notices disregarded until the earlier of (a) 1 year from the date the individual was first eligible for relief or (b) 60 days after the announced end of the National Emergency (the end of the Outbreak Period). On the applicable date, the timeframes for individuals and plans with periods that were previously disregarded under the Notices will resume. In no case will a disregarded period exceed 1 year.

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20

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2021 Outbreak Period Guidance

- Basically, identify the original due date (but for the Outbreak Period) and add 1 year (per the examples in the guidance).
  - COBRA election period would have otherwise ended May 31, 2020. Plan can require election by May 31, 2021.
  - Health FSA run out period for 2019 plan year would have otherwise ended March 31, 2020. Plans can require submission of 2019 claims by March 31, 2021.
  - 1 year period for filing health plan claim would have otherwise ended July 31, 2020. Plan can require filing of claim by July 31, 2021.

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21

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2021 Outbreak Period Guidance

- IRS Notice 2021-58
  - Addressed the application of outbreak period to initial premium payment deadline when electing outside of the original 60 day period
    - 1 year period for initial premium runs concurrently with election period (105 days after receipt of election notice)
  - Notwithstanding the above rule, no initial premium due prior to November 1, 2021, even if beyond the 105 day period, unless 1 year and 45 days has already expired

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ARPA COBRA Subsidy

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23

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ARPA COBRA Subsidy

- Overview of 100% COBRA subsidy
  - AEIs are QBs who elect COBRA within the subsidy period due to a qualifying event of ***reduction in hours or involuntary termination of employment***
    - Not eligible for Medicare or other group health plan coverage
  - Subsidy period is 4/1/21 to 9/30/21
    - But not beyond maximum COBRA coverage period
  - Extended election period allows 60 days to enroll in subsidized COBRA effective 4/1/21
  - May give AEIs 90 days to enroll in a different coverage option (no greater premium)
  - Must notify AEIs about availability of subsidy, extended election period, and when the subsidy is expiring (between 45 and 15 days before the expiration date)
  - For plans subject to federal COBRA, coverage is generally paid by the employer, which is then reimbursed via payroll tax credit

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24

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ARPA – DOL Guidance

- On April 7, 2021 DOL issued the following guidance:
  - FAQs about the subsidies;
  - A summary of subsidies;
  - A model general notice and election notice;
  - A model notice in connection with the extended election period;
  - A model alternative notice; and
  - A model notice of expiration of subsidies.

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ARPA – COBRA SUBSIDY

- IRS Notice 2021-31 addressed
  - (1) Eligibility for COBRA Premium Assistance;
  - (2) Reduction in Hours;
  - (3) Involuntary Termination of Employment;
  - (4) Coverage Eligible for COBRA Premium Assistance;
  - (5) Beginning of COBRA Premium Assistance Period;
  - (6) End of COBRA Premium Assistance Period;
  - (7) Extended Election Period;
  - (8) Extensions Under the Emergency Relief Notices;
  - (9) Payments to Insurers Under Federal COBRA;
  - (10) Comparable State Continuation Coverage;
  - (11) Calculation of COBRA Premium Assistance Credit; and
  - (12) Claiming the COBRA Premium Assistance Credit.

ARPA Subsidy—subsequent guidance

- IRS Notice 2021-46
  - Those whose are still in second qualifying event notice period due to outbreak period can still receive subsidy for any portion of that period that falls in the ARPA subsidy period if they timely elect (in accordance with outbreak period)
  - Additional guidance on claiming the credit
    - E.g. each controlled group member participating in a plan is entitled to the credit.

27

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FSA Relief Under CAA And Answers From IRS Notice 2021-15

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28

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FSA Relief Under CAA

- Elective Temporary Relief for Health and DCAP FSAs (Pub. L. No. 116-260, Div. EE, § 214 (2020))
  - Carryover of unused FSA funds from PYs ending in 2020 or 2021
  - Extended grace periods for PYs ending in 2020 or 2021
  - Post-termination Health FSA spend-down following termination of participation in CYs 2020 or 2021
  - Temporary Expansion of Eligible DCAP Dependent to Age 13 for 2020; also for 2021 for Unused DCAP Grace Period or Carryover Funds
  - Election changes in PY ending in 2021 without change in status event
- Compare and Contrast 2020 Relief under IRS Notice 2020-29

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Carryover of Unused FSA Funds

- Details
  - Health FSA and DCAP balances that are unused in PYs ending in 2020 may be carried over into PY ending in 2021, and unused balances in PYs ending in 2021 may be carried over into PY ending in 2022.
  - There is no cap on the amount of permitted carryover. Also, DCAPs can use carryover whereas the 2020 IRS Notice allowed a carryover only for health FSAs (not DCAPs).
- Employers that offer an HDHP should consider steps to protect ongoing Health Savings Account (HSA) eligibility for employees participating in a general-purpose FSA (*e.g.*, allowing a waiver of coverage or by restricting carryover funds in a health FSA for those who elect an HDHP to limited purpose vision/dental coverage).
- DCAP benefits are subject to Form W-2 and participant reporting requirements
  - How to handle W2 reporting?
  - How to handle $5000 cap?
  - Further guidance expected revising Form 2441 for carryover and grace period to clarify that carryover/grace period amounts not taxable during relief period.

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Extended Grace Period

- Details
  - The Act permits a grace period for unused benefits in health FSAs and DCAPs to be extended up to 12 months for plan years ending in 2020 or 2021.
- As with the carryover, ongoing grace period coverage in a general-purpose health FSA would make an individual ineligible for an HSA for the entire period of coverage.
  - Employers that offer an HDHP and are considering the grace period extension for a general- purpose health FSA should consider steps to protect ongoing HSA eligibility (*e.g.*, by limiting the grace period duration or by restricting the use of unused funds for participants to limited purpose vision/dental coverage).
  - Per Notice 2021-15 HSA restriction applies for entire grace period to current participants AND participants who are eligible to incur claims but have ceased participation due to termination of election due to employment or change in status

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Post-termination Health FSA Spend-down

- Details
  - Plans may permit Health FSA participants who terminate participation in the plan during 2020 or 2021 to spend down their unused balances for expenses incurred through the end of the plan year in which the termination occurred, including any grace period extension.
  - This approach is similar to what is and has always been permitted for DCAPs.
  - Under such an approach, FSA reimbursements can be limited by plan design to the amount of unused FSA contributions.
- Steps should be taken to coordinate the spend down with any COBRA coverage required for the health FSA.
  - Presumably, the spend down would be offered as an alternative to COBRA coverage, but Notice 2021-15 provides that they could run concurrently.
- As with the grace period extension and carryover provisions, ongoing coverage in a general-purpose FSA will adversely impact HSA eligibility for the entire period of coverage.

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Temporary Expansion of Eligible DCAP Dependent to Age 13

- Details
  - Normally, DCAP benefits may be provided for eligible dependents through age 12 (*i.e.*, dependents who have not turned age 13).
  - The Act permits employers to amend their plans to reimburse DCAP expenses for eligible dependents through age 13 (*i.e.*, dependents who have not attained age 14) for the 2020 plan year.
  - In order for this relief to apply, the plan's regular annual enrollment period must have ended on or before Jan. 31, 2020.
  - The same relief also applies for the next plan year, but only for unused grace period amounts from the 2020 plan year or other amounts carried over into the 2021 plan year.
- Plan sponsors seeking to avail themselves of this change should ensure that they can differentiate between carryover and non-carryover funds in processing claims for age 13 dependents.

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Election Changes in PY Ending in 2021

- Details
  - Prospective changes in health FSA and DCAP elections may be made for plan years ending in 2021 without a corresponding change in status event.
  - IRS Notice 2021-15 expands this relief to health (medical, dental, vision) coverage as well. This is consistent with the relief provided in IRS Notice 2020-29.
- Employers considering such a provision may want to impose reasonable restrictions on the number of such changes and restrict prospective FSA reductions to be no lower than amount of benefits already paid

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Points to Ponder

- Should Changes be Adopted
  - How many participants impacted (will "normal" carryover/grace period work)
  - How much is at stake
  - Potential impact on HSA eligibility
- Timing considerations
  - Amendments can be adopted until end of calendar year that begins following plan year for which change adopted
  - Earlier communications required

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35

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IRS ARPA and CAA 2021 Dependent Care Guidance Notice 2021-26

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36

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ARPA DCAP Increase to $10,500

- Employers may amend a DCAP plan retroactively so long as the amendment is adopted by the last day of the plan year in which the amendment is effective and the plan is operated in accordance with the amendment's terms beginning on its effective date.
  - Is an amendment needed? Does your plan reference the statutory limitation or the static dollar amount?
  - Can increases in elections be made under current election change (change in cost or coverage) provisions?
- Don't forget:
  - Separately under the Consolidated Appropriations Act, 2021, an employer can amend its DCAP for 2020 and/or 2021 to:
  - (1) Allow a 12-month grace period or carryover for amounts that remain unused at the end of each of those years;
  - (2) Increase the dependent childcare age to 13 for 2020 and 2020 carryover amounts;
  - Allow open ended DCAP election changes

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37

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ARPA DCAP Increase Practice Pointers

- Prudently consider 2021 Midyear Election Changes
  - Take note of any unused 2020 DCAP amounts that become incurred in 2021 due to an extended grace period or carryover provision adopted by the employer.
  - Unclear whether employees should be allowed to increase their 2021 DCAP elections to an amount that, when combined with the amount still available from 2020, exceeds the new $10,500 exclusion limit for 2021.
- Analyze Nondiscrimination Requirements and Previous Testing Results
  - Employers that previously experienced difficulty passing DCAP nondiscrimination requirements may decide not to allow employees to increase 2021 DCAP midyear elections.

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38

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ARPA DCAP Increase Practice Pointers

- IRC Section 129 nondiscrimination requirements remain unchanged for 2021. Consider specifically the Average Benefits Test which requires that the average benefit provided to non-HCEs equal at least 55% of the average benefits provided to HCEs. Employers could limit the ability to increase 2021 DCFSA elections to non-HCEs only, but that may only result in a more complex administrative burden.
- Monitor New Legislation Affecting the 2022 Exclusion Limit
- ARPA does not extend to 2022; at present, any unused DCFSA amount from 2021, that remain available for use in 2022, will be subject to the prior $5,000 limit (any expenses over such amount becomes taxable in 2022).

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CAA 2021, ARPA, and Dependent Care Plans

- IRS Notice 2021-26 https://www.irs.gov/pub/irs-drop/n-21-26.pdf integrates two recent DCAP developments
  - ARPA temporarily increases the benefit limit for DCAP to $10,500 for the ***taxable year*** beginning after December 31, 2020, and before January 1, 2022 (i.e. ***the 2021 calendar year)***.
  - CAA 2021 allows DCAPs to carry over unused benefits from a ***plan year ending in 2020*** to a plan year ending in 2021 and from a ***plan year ending in 2021*** to a plan year ending in 2022. Alternatively, the CAA allows a DCAP to extend its claims/grace period for a ***plan year ending*** in 2020 or 2021 to 12 months after the end of the plan year with respect to unused benefits remaining in the DCAP.
- Pre- CAA 2021 excess DCAP is taxable if the amount carried over when combined with the elected benefit paid within a calendar year exceeds the annual limit. .
  - For example, if I had $500 left for 2019 in a calendar year plan and carried over $500 into the grace period in 2020 and also elected $5,000 for 2020 and was reimbursed $5,500 in 2020 I would have $500 in income in 2020 because the total reimbursed in the calendar year exceeded the $5,000 limit. This is true even though my annual elections (ignoring the carryover) would not have exceeded any statutory limits.
- IRS Notice 2021-26 together with Notice 2021-15 changes this rule ***temporarily***. Neither carryovers nor extended grace periods for 2020 plan years into 2021 or 2021 plan years into 2022 will adversely affect taxation.
- Notice 2021-26 addresses how non-calendar year DCAPs are impacted
  - The increase to $10,500 applies to tax (calendar) years while the carryover and grace period rules apply to ***plan year ending in 2020*** to a plan year ending in 2021 and from a ***plan year ending in 2021*** to a plan year ending in 2022.
  - This effectively means that the 2021 DCAP increase is only available for expenses reimbursed in calendar year 2021 while the carryover/grace period exclusions under CAA are available for both 2021 and 2022 plan years.

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IRS guidance addressing PPEs

- IRS Announcement 2021-07
  - Allows PPE for personal protective equipment, such as masks, hand sanitizer and hand sanitizing wipes, for the primary purpose of preventing the spread of COVID as amounts paid for medical care under § 213(d)
    - *Not as broad as many think – may not apply to surface disinfectants.*
  - How do you administer primary purpose requirement?
  - Allows treatment retroactively to January 1, 2020
  - Is a plan amendment required?
  - Are election changes allowed?

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41

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CAA 2021: Compensation Disclosure and MHPAEA

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42

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Broker and Consultant Disclosure

- Brokers and Consultants are required to make disclosures if they receive $1,000 or more in total annual direct and indirect compensation.
- Covers group health plans which would include excepted benefits like stand alone dental and vision, Health FSAs, certain EAPs as well as HRAs.
- Disclosure is required under Section 408(b)(2) of ERISA and is very similar to retirement plan disclosures that have been required since 2012.
- The definition of brokerage services includes services with respect to "selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services.

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Broker and Consultant Disclosure

- Consulting services are nearly identical but do not need to involve "brokerage" and include those "related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), record keeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services."
- Unclear whether consulting just involves brokers serving in a consulting capacity (e.g. for a self-funded plan) or other service providers who "consult" such as a TPA consulting on plan design and implementation.
  - Hopefully there will be further guidance.

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Broker and Consultant Disclosure

- Direct compensation is compensation from the plan itself (plan assets).
- Amounts paid by the employer/plan sponsor would not be considered plan assets but participant contributions are always plan assets.
  - Careful analysis of whether plan assets are involved in determining the $1,000 threshold.
  - Analysis much more difficult than in the retirement plan context (where there is almost always a trust) and we hope for additional guidance.
- Indirect compensation is generally amounts received from anyone other than the plan or the employer/plans sponsor (e.g. consultant receives compensation from a TPA or from an insurer not in the form of commissions)
- Group health plan Insurance commissions would seem to always count toward the $1,000 threshold.

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Broker and Consultant Disclosure

- Nine broad categories of required disclosures similar to retirement plan disclosures describing services and compensation.
- If disclosures are not provided plan fiduciaries must take a series of actions including ultimately notifying DOL and terminating the service provider in order to avoid a prohibited transaction.
- Effective date is for contracts or arrangements entered into (or extended) after December 27, 2021.

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Broker and Consultant Disclosure

- Take Aways/Action Items for plan administrators and other plan fiduciaries
  - Identify all consultants and brokers with respect to any group health plan.
  - Determine whether any service provider receives any direct compensation and the amount of that compensation.
  - If known, determine whether the service provider receives any indirect compensation and the amount of that compensation.
  - Be prepared, beginning next January, to make a demand to any covered service provider who has not provided adequate disclosure.
  - Establish and document that a responsible fiduciary actually reviews the disclosures and determines that the compensation is reasonable.

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Broker and Consultant Disclosure

- Take Aways/Action Items for brokers and consultants
  - Identify all group health plans where brokerage or consulting services are provided.
  - Determine all sources of direct and indirect compensation.
  - Determine whether direct and indirect compensation meets the $1,000 threshold.
  - Design and format (and presumably automate) the disclosures to include the required information for timely delivery.

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Required Mental Health Parity Analysis

- The NSA further expands the Mental Health Parity and Addiction Equity Act (MHPAEA).
- MHPAEA requires parity between certain aspects of medical/surgical (Med/Surg) benefits and mental health/substance use disorder (MH/SUD) benefits.
- As a general rule, nonquantitative treatment limitations (NQTLs) cannot apply any more stringently to MH/SUD benefits than they apply to Med/Surg benefits.
- NQTLs are non-numerical/non-dollar limits on the duration or scope of benefits, such as medical necessity and prior authorization.
- Parity must not only be on the face of the plan ***but also in operation***.
- DOL audits now can span several years over MHPAEA issues and NQTLs and private MHPAEA litigation is on the rise.

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49

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Required Mental Health Parity Analysis

- The Act now requires a written five-part NQTL analysis
  - Identification of the NQTLs
  - Factors considered in the design of the NQTL. Examples include:
    - Excessive utilization
    - Recent cost escalation
    - Lack of clinical efficiency
  - Evidentiary standards and sources used to develop the factors. Examples include:
    - Internal claims analysis,
    - Medical expert reviews,
    - National accreditation standards;
  - A comparative analysis of the NQTLs as written and in operation
  - Findings and conclusions establishing compliance.

50

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50

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Required Mental Health Parity Analysis

- DOL, HHS and the IRS can each request the analysis.
  - Each Agency must request at least 20 per year.
- State regulators (e.g. state departments of insurance) can also request.
- Agency request likely triggered by individual complaints but Agency can request in any instance it deems appropriate.
- Must be available, upon, request 45 days after enactment or ***February 10, 2021.***
- If Agency finds the plan is non-compliant then there is a 45 day "cure period."
  - If not cured then the Agency will notify all enrolled in the plan of the non-compliance.
- Agencies will provide further guidance on NQTLs within 18 months of enactment.

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Required Mental Health Parity Analysis

- DOL has issued several useful tools with regard to NQTLs:
  - Self-Compliance Tool
  - A listing of MHPAEA NQTL Warning Signs.
  - A Report to Congress including an "under the hood" look at a MHPAEA audit.
  - MHPAEA Enforcement Fact Sheet
- Take Aways/Action Items
  - A MHPAEA NQTL analysis is complex and time consuming.
    - What is (and is not) a compliant NQTL is a constantly developing area of MHPAEA compliance
  - Start now if a NQTL analysis has not been done.
  - If an analysis has been done, review it to make sure it contains the statutorily required elements.
  - For self-funded plans, the TPA or ASO will likely have the most knowledge.
    - Review/revise service provider contracts with respect to MHPAEA compliance and the NQTL analysis.
  - Self-Compliance Tool is a good place to start.

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MHPAEA Comparative Analysis

- FAQs Part 45 (Apr. 2021)
  - Format of Comparative Analysis
    - Comparative analysis for each NQTL must be sufficiently detailed and reasoned
    - Conclusory or generalized statements without specific supporting evidence and detailed explanations are insufficient
    - Include supporting information (e.g., claim processing policies, samples of claims)
    - Follow guidance in the MHPAEA Self-Compliance Tool
  - Participant Access
    - Plan participants are entitled to obtain a plan's comparative analyses and supporting information upon request
    - Claimants may request in conjunction with an appeal of an adverse benefit determination

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53

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Benefit Aspects of WORKSITE COVID Testing and Vaccination Incentives

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COVID Testing and Vaccinations

- Fourteen FAQs issued on February 26, 2021
  - https://www.cms.gov/files/document/faqs-part-44.pdf
- Testing
  - Plans may not impose medical screening criteria to deny or impose cost sharing for testing on asymptomatic individuals.
  - Plans are not required to cover testing for public health surveillance or employment purposes.
  - Plan are required to cover testing provided through governmental administered testing sites as well point-of-care tests.
  - Plans need to take steps to protect participants from inappropriate cost sharing for services related to testing and the Agencies will take enforcement action to insure those protections.

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COVID Testing and Vaccinations

- Vaccinations
  - Plans must cover, without cost sharing, all approved vaccines within 15 business days after their recommendation. January 5th for Pfizer and January 12th for Moderna.
  - Plans need to cover the vaccine administration fee even where the government or another party pays for the vaccine itself.
  - Plans may not deny coverage for a vaccine based on an individual not being in a current category recommended for early vaccination.
  - Agencies will take no action concerning the 60-day advance notice requirement for changes to a SBC with regard to the vaccine as long as notice is provided as soon as reasonably practicable.
  - Employers may offer vaccines through an EAP and it will not be considered to provide "significant benefits in the nature of medical care" allowing the EAP to qualify as an excepted benefit under the ACA.
  - Excepted benefit status also exists for vaccines provided through onsite clinics.

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56

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Vaccination Incentives/Surcharges: Benefits Areas of Concern

- Five FAQs issued October 4, 2021 https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-50.pdf
- Primary concern is the HIPAA Nondiscrimination Rules
  - FAQs-Part 50 confirm that HIPAA Rules Apply
  - Potential excise taxes of $100 per day per impacted individual under IRC §4980D and/or specific enforcement under ERISA
- Other areas –
  - Americans With Disabilities Act (ADA) and Genetic Information Nondiscrimination Act (GINA)
  - ACA Employer Shared Responsibility Affordability Penalty ("ESRP")
  - Title VII
    - Reasonable accommodation for those that have sincerely held religious beliefs
  - Costly litigation even if employer prevailed

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HIPAA Nondiscrimination Rules

- Requirements for a non-discriminatory program:
  - Total Reward cannot exceed 30% of the total costs of single coverage (or family coverage if dependents are allowed to participate)
    - Total Reward includes all other non-smoking related rewards
    - Cost of coverage is COBRA premium w/o 2% fee
  - Qualify for the Reward at least once per year
  - Must be available to all similarly situated individuals
  - Notice that a reasonable alternative will be provided
  - Must be reasonably designed to promote health or prevent disease

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ADA and GINA

- Title I of the ADA prohibits disability-related medical examinations and inquiries with two exceptions:
  - Medical examinations or inquiries if they are "job-related and consistent with business necessity"
  - Voluntary medical examinations, including medical histories and disability-related inquiries, that are part of an employee health program
- EEOC FAQ guidance provides that requesting proof of vaccination from community providers (*e.g.,* pharmacy, health department) is not a disability-related inquiry for ADA purposes
- If employer or its agent provides the vaccinations, information obtained in the screening process would likely be a disability-related inquiry
  - Would likely impact GINA as well if offered to employees' spouses or other family members
  - Any incentive cannot be "so substantial as to constitute coercion"

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ACA Affordability

- If offer the vaccine incentive, then all full-time employees must be treated as if they failed to obtain the Reward for affordability calculations
- Implementing incentive mid-year may raise some issues under ESRP rules and require employers to allow employees to drop coverage if unaffordable
- ESRP excise taxes are non-deductible for full-time employees who decline unaffordable employer coverage and receive a subsidy on a governmental exchange
- Also note that a mid-year increase raises some issues under the IRC §125 plan rules with regard to permitted election changes for significant plan increases
  - Waiting to annual enrollment to implement a vaccine incentive might be simpler if an employer wants to move forward

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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

62

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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")

63

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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

64

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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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66

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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 "recognized 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
    - "initial payment" 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 "initial payment" to the provider be?
  - Determine who is handling the public and individual disclosures?
- Amend SPDs
  - Are SBCs affected?
- Post Balance Billing Protections Notice and include in EOBs.
- Amend contracting procedures to account for gag clause prohibition and brokerage/consulting compensation disclosures

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75

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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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76

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Additional Items to Note

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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
- State ACA Reporting
- Additional State Mandates
  - WA, CA, etc

78

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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	2850
Health FSA carryover max	$550	570
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)	5450 (11,050)
Transit and parking benefits	$270 (monthly)	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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79

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Thanks!

- Questions?

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80