TOWN HALL SERIES

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Compliance Mid-Year Review

WEDNESDAY
JULY 13, 2022

2 P.M. ET ▪ 1 P.M. CT
12 P.M. MT ▪ 11 A.M. PT

4,014 Organizations

December 2021 to March 2022

"The era of standardized employee benefits and wellbeing solutions is over"

Meet Your Gallagher Speakers

Sally Wineman, J.D.

Area Senior Vice President, Compliance Counsel

Kim Mitchell, J.D.

Divisional Vice President, Compliance Counsel

Andrew Malahowski, J.D.

Area Senior Vice President, Compliance Counsel

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Sally Wineman

Gallagher

Recent U.S. Supreme Court Ruling

- U.S. Supreme Court ruled *Dobbs v. Jackson Women's Health Organization*, overturning *Roe v. Wade*
- **State governments** now have the ability to enact more restrictive abortion laws, including complete bans

Federal Laws

Considerations in a fluid situation

The Pregnancy Discrimination Act (PDA)

Does not require employer-sponsored group plans to pay for reproductive and family planning benefits, except where the life of the mother would be endangered if the fetus were carried to term.

A plan must also cover medical complications that arise from an abortion.

The Equal Employment Opportunity Commission (EEOC)

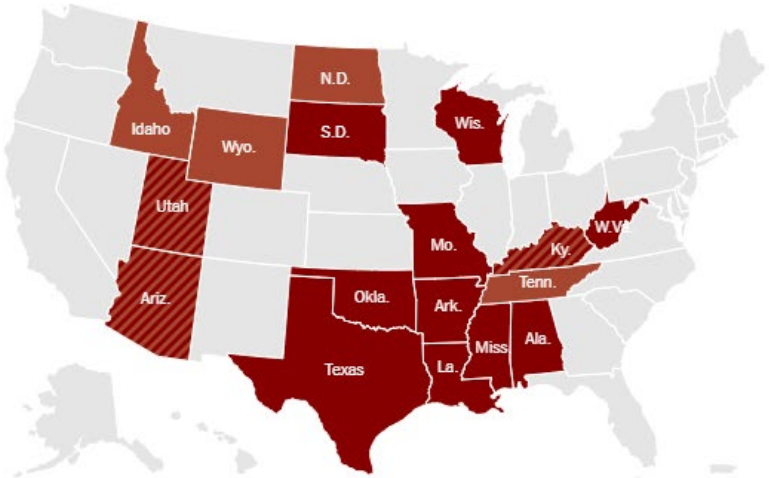
If an employer covers the cost of reproductive and family planning benefits, the EEOC indicates that the plan must do so in the same degree as it covers medical conditions.

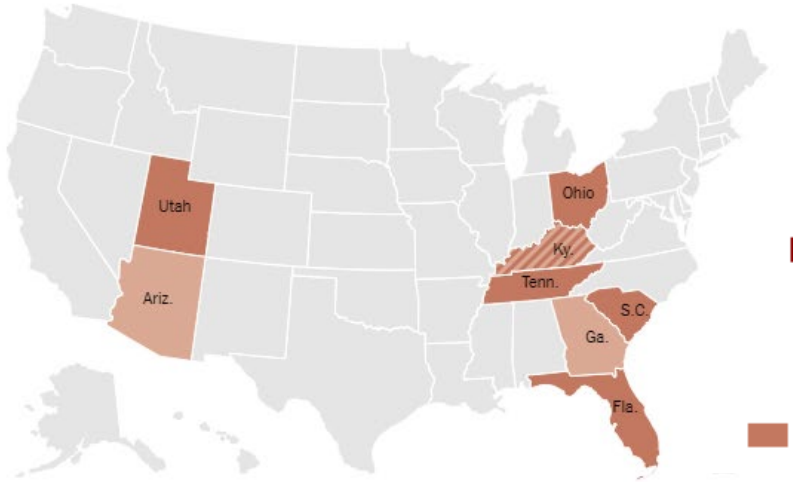
Both PDA and EEOC guidance is unaffected by the U.S. Supreme Court Ruling, meaning…

Group health plans will remain subject to PDA.

State Law Impact

Legal Status by State (Changing)



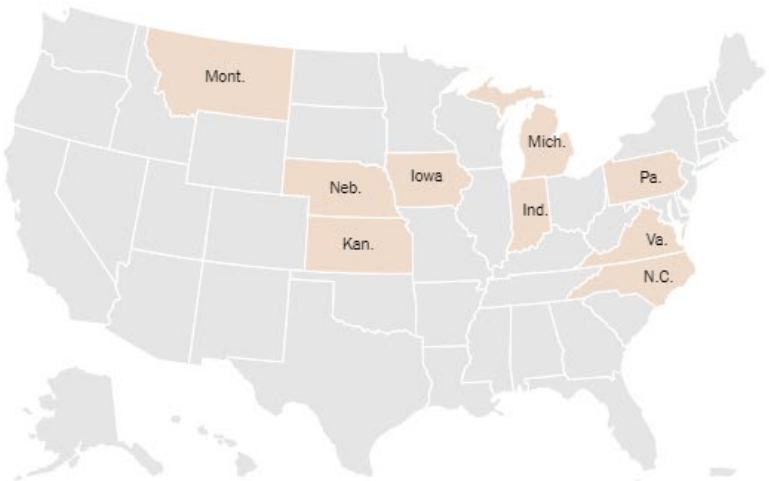


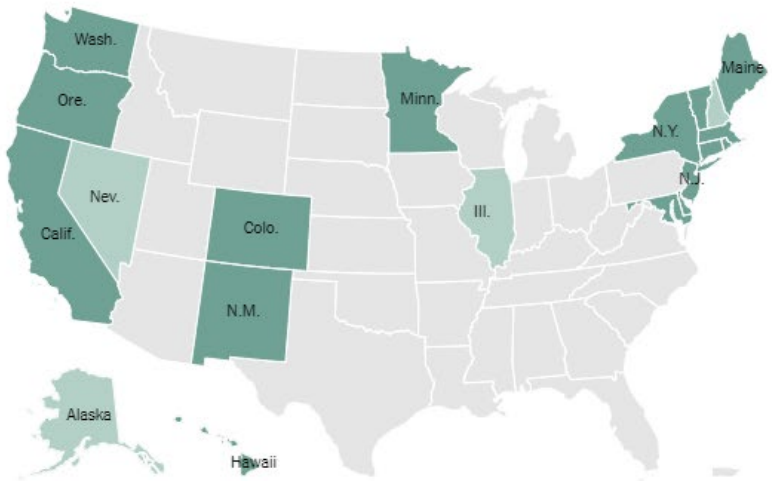
Prohibited

Ban in effect | Expected soon | Ban blocked

Restricted

Gestational limit in effect | Expected soon | Blocked





Legal for now

Lawmakers or courts will decide

Legal

Protected | Expanding access

Source: July 11, 2022. https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html

Employer Considerations

Steps to Understand

Current Offerings

- Determine what the plan(s) currently offer.
- Remember that a client may have both a self-insured plan and a fully-insured plan which may have different benefits.

State Laws

- Consider impact of state laws on fully-insured plans.
- Some states have criminal statutes that make it a crime to aid someone who is seeking an abortion.

Travel Benefits

- Consider whether carrier or TPA can handle travel benefits as employer likely wouldn't want to administer.
- Limitations on reimbursements apply.

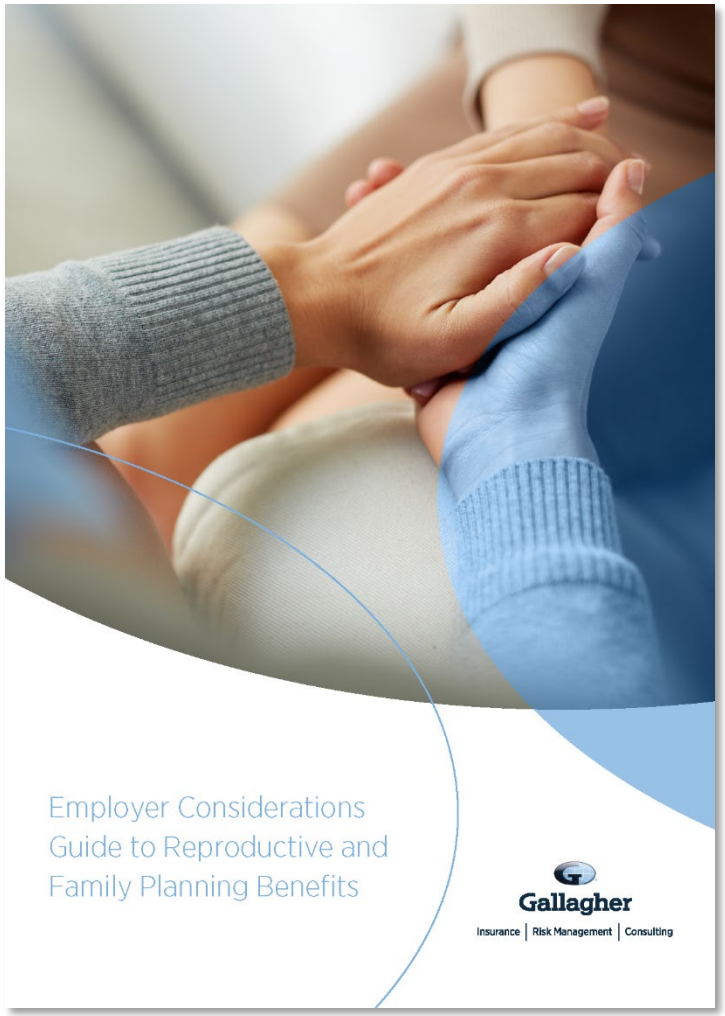
Travel Benefits

Medical care includes amounts paid for transportation primarily for and essential to medical care

- Limit of $50 per night for lodging
- If travel by car, mileage rate is 22¢ per mile, effective 7/1/22
- Meals are only reimbursable if obtain within hospital, etc. where procedure is performed
- Potential issues under mental health parity rules if limit to reproductive and family planning benefits

***Offer travel benefits for employees who reside in states that do not allow abortion services only after consulting with legal counsel

More Coming

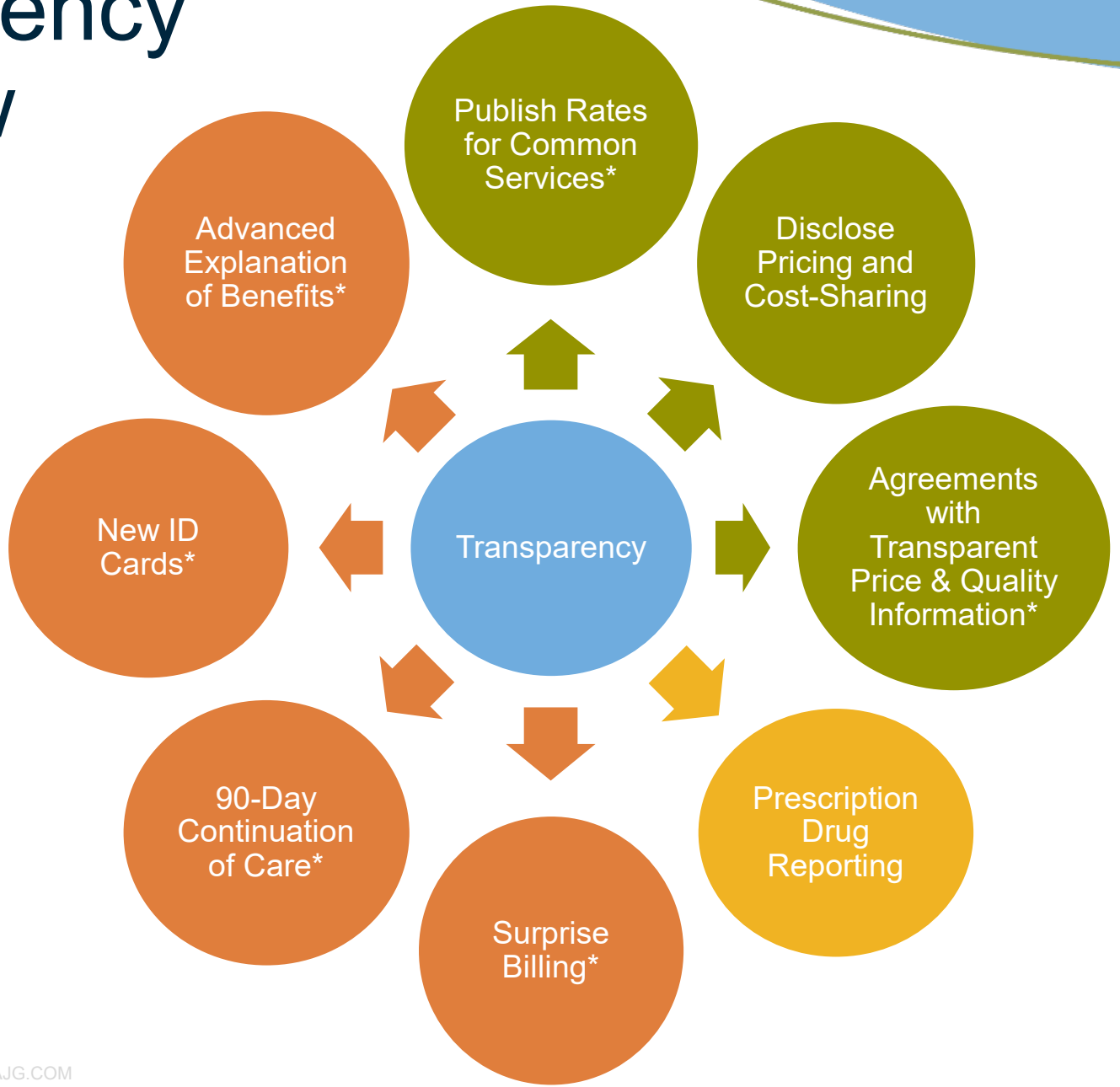


Items to Archive

- FFCRA Leave
- COBRA Subsidy
- Supreme Court ACA Ruling
- Cafeteria Plan COVID-19 Relief*
- FSA/DCAP Expanded Grace Periods or Carryovers
- HSA Telehealth Temporary Relief*

***Outbreak Period and Telehealth extensions continue**

Transparency Overview



*Effective for plan years beginning on or after January 1, 2022

Transparency

Adequate Consultant Compensation Disclosure

For Agreements entered into on or after December 27, 2021:

- Must disclose direct and indirect compensation
- Including commissions and other incentive compensation
- Applies to contracts on or after 12/27/21

Applies to services related to:

- Selection of insurance products,
- Recordkeeping services,
- Medical management vendor,
- Benefits administration,
- Stop-loss insurance,
- Pharmacy benefit management,
- Wellness,
- Transparency tools and vendors,
- Group purchasing organization preferred vendor panels,
- Disease management,
- Compliance services,
- EAPs, and
- Third party administration

Surprise Billing

Plan years beginning on or after January 1, 2022

REQUIREMENT

- Special rules for handling balance billing for emergency services and non-emergency services at in-network facilities.
- **Notice must be publicly available, posted on plan's website and included on applicable EOBs.**

STATUS

- Currently applies (based on plan year).
- **DOL is modifying process as a result of a recent court decision.**

Other Transparency Rules

When is it Applicable?

Plan years beginning on or after January 1, 2022

Accurate Provider Directories

Must be updated at least every 90 days

Continuation of Care

Must continue care for up to 90 days in certain circumstances at in-network rates

Updated ID Cards

Must include deductible, OOP, and consumer assistance information

"APPLY GOOD FAITH, REASONABLE INTERRPRETATION OF THE LAW, PENDING FURTHER GUIDANCE"

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Machine-Readable File Postings

Requirements applied July 1, 2022

In-Network Rates

Negotiated rates for all covered items and services between the plan or insurer and in-network providers.

Payments to Out-of-Network Providers

Historical payments to, and billed charges from, out-of-network providers.

Delayed Until Further Guidance

Prescription Drugs

In-network negotiated rates and historical net prices for all covered prescription drugs by plan or insurer at the pharmacy location level.

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Machine-Readable File Postings

Can someone do it for me?

Fully-Insured Plan	Self-Insured Plan
Yes, you can have a written agreement to shift liability from plan to carrier.	Yes, you can have ASO, TPA, or PBM report, but plan is still liable.

NOTE: Group health plans and carriers must disclose machine-readable negotiated rate files (MRF) information on a *public website.*

Pharmacy Benefit and Cost Reporting

What is the Rule?

Annual reporting on prescription drug benefits and costs, including:

- the 50 brand drugs most frequently dispensed for the plan;
- the 50 most costly drugs by total spend; and
- 50 drugs with greatest increase in expenditures over preceding plan year; and more.

When is it Applicable?

Originally – December 27, 2021 and each June 1 thereafter.

Now – Delayed until December 27, 2022. The first report will need to include 2020 and 2021 data.

Ongoing – Ongoing report will be due each June (effective June 1, 2023).

Practical Tips

- You will need data and assistance from the Insurer, TPA, or PBM to report.
- If you have transitioned carriers or PBMs across the 2020-2022 calendar years, work with your vendors to determine reporting responsibilities.
- Enter into a written agreement and determine any additional charges.

Upcoming Transparency Rules

What's Next?

Price Comparison Tools

500 Items and Services

Plan Years beginning on or after January 1, 2023

Price Comparison Tools

All Items and Services

Plan years beginning on or after January 1, 2024

Advanced Explanation of Benefits

Delayed

Pending further guidance

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Vaccine Incentives & Mandates - Timeline

MAY 2021

EEOC provided an explanation of when ADA and GINA rules apply.

JAN. 2022

US Supreme Court blocked OSHA's Nov. 2021 ETS that employees at large businesses be vaccinated against COVID-19 or undergo weekly testing.

SINCE JAN. 2022

- Court allowed the administration to proceed with the CMS's November 2021 vaccination rules applicable to most health care workers in the U.S.
- September 2021 Executive Order requires federal contractors to implement a vaccine mandate, but this Order was enjoined in court, and the government has halted enforcement efforts for the Order.
- OSHA is likely to release a permanent rule in this area, but will not simply re-release the original ETS.
- OSHA general duty clause remains in place.
- State and local laws are mixed.

MARCH 2022

EEOC issued FAQs regarding responding to requests for religious exemptions.

OCT. 2021

An agency FAQ confirmed vaccine incentives/surcharges are subject to more detailed regulations under HIPAA / ACA.

Coverage of COVID Testing, Vaccines, and Treatment

What is the Rule?

Diagnostic COVID-19 testing: Cover without cost-sharing when ordered by an attending health care provider.

OTC COVID-19 testing: Cover with no cost-sharing even without an order by a health care provider.

COVID-19 Vaccines: Non-grandfathered group health plans cover without cost-sharing.

COVID-19 Treatment: Not required to cover without cost-sharing under federal law (but a few states required or secured agreements with insurers to waive cost-sharing for fully-insured plans).

When is it Applicable?

- The testing and vaccine coverage mandates apply during the Public Health Emergency (declared and then extended by HHS – most recently extended again until July 15, 2022).
- The OTC COVID-19 testing coverage mandate applies to tests purchased on or after January 15, 2022 and for the remainder of the Public Health Emergency.

Practical Tips

- The testing coverage mandate does not apply to tests that are solely employment related.
- While the federal government continues to pay the cost of the vaccine itself, plans must pay the costs of administering the vaccine.

OTC COVID-19 Testing

Direct Coverage

- Not required to provide direct coverage.
- May NOT limit testing to ONLY preferred network or direct coverage retailers. Must offer participant reimbursement option as well.
- However, may limit reimbursement amount for non-preferred retailers to the lesser of $12 per test or actual cost if offer direct coverage.
- May limit to 8 OTC tests per participant per 30 days and require attestation of personal use and proof of purchase.

Participant Reimbursement

- No cost-sharing, prior authorization or medical management.
- May limit reimbursement to lesser of $12 per test or actual cost if offer direct coverage option as well.
- Participant must submit a claim for reimbursement.
- No Health Care Provider order needed.
- May limit to 8 OTC tests per participant per 30 days (or calendar month) if health care provider not involved.
- May require attestation of personal use and proof of purchase.

Practical Tips

- No reimbursement or direct coverage required for employment related OTC COVID-19 tests.
- Quick effective date (**January 15, 2022**), so carriers and TPAs may scramble to provide adequate process for reimbursement and direct coverage access
- Still must ensure adequate access to and awareness of the OTC COVID-19 retailers or limits on reimbursement amounts will not apply

Public Health Emergency

Still in effect

- Requires coverage of COVID-19 testing, including OTC tests.
- Requires coverage of COVID-19 vaccines, including out-of-network providers.
- Expected to be extended beyond the current July 15 end date.

COVID-19 Response

Permissible Expenses

Over the Counter Medications	Menstrual Care Products	Personal Protective Equipment (PPE)
Can use funds to pay for OTC drugs without a prescription	**HSAs and health FSAs can be used to purchase menstrual products**	**HSAs and health FSAs can be used to purchase PPE**
This relief applies for amounts paid and expenses incurred beginning in 2020	This relief applies for amounts paid and expenses incurred beginning in 2020	This relief applies for amounts paid and expenses incurred beginning in 2020

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Outbreak Period Continues

What is the Rule?

Individuals have an **additional year beyond the regular deadline** to:

- elect COBRA;
- pay for COBRA; and
- enroll in a health plan pursuant to HIPAA special enrollment rights.

(Claims and appeals deadlines under ERISA are also affected.)

When is it Applicable?

March 1, 2020 – Current

The regular deadline period is "disregarded" until the **earlier** of the following:

- one year from the date they were first eligible for relief, or
- 60 days after the announced end of the National Emergency (the end of the Outbreak Period).

The DOL also stated that "In no case will a disregarded period exceed 1 year."

Practical Tips

- Beware of treating participant elections as "late" – they may not be late.
- Outbreak Period relief does not apply to all mid-year election change rights (for example, those permitted under your cafeteria plan). Instead, it is far more limited.
- Optional, but encouraged, for non-Federal governmental plans

End of National Emergency

Impact on Outbreak Period Rules

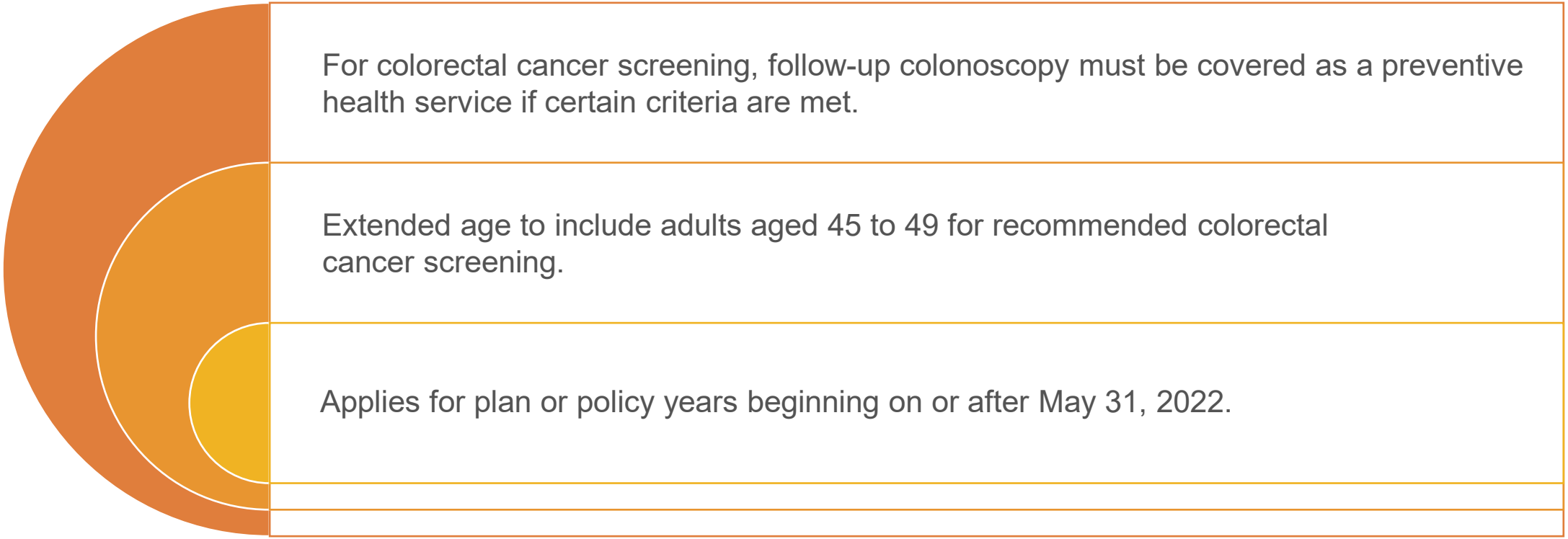
If a qualified beneficiary would have been required to make a COBRA election **by March 1, 2021**, the guidance delays that deadline until the earlier of 1 year from that date (i.e., March 1, 2022) or the end of the Outbreak Period.

And since the **Outbreak Period hasn't yet ended**, the earlier of those dates is **March 1, 2022**.

When the end of the National Emergency is announced, there will be some deadlines that are **tolled for less than one year** – specifically, because the date that is 60 days after the end of the National Emergency will be earlier than the date that is one year from the regular deadline.

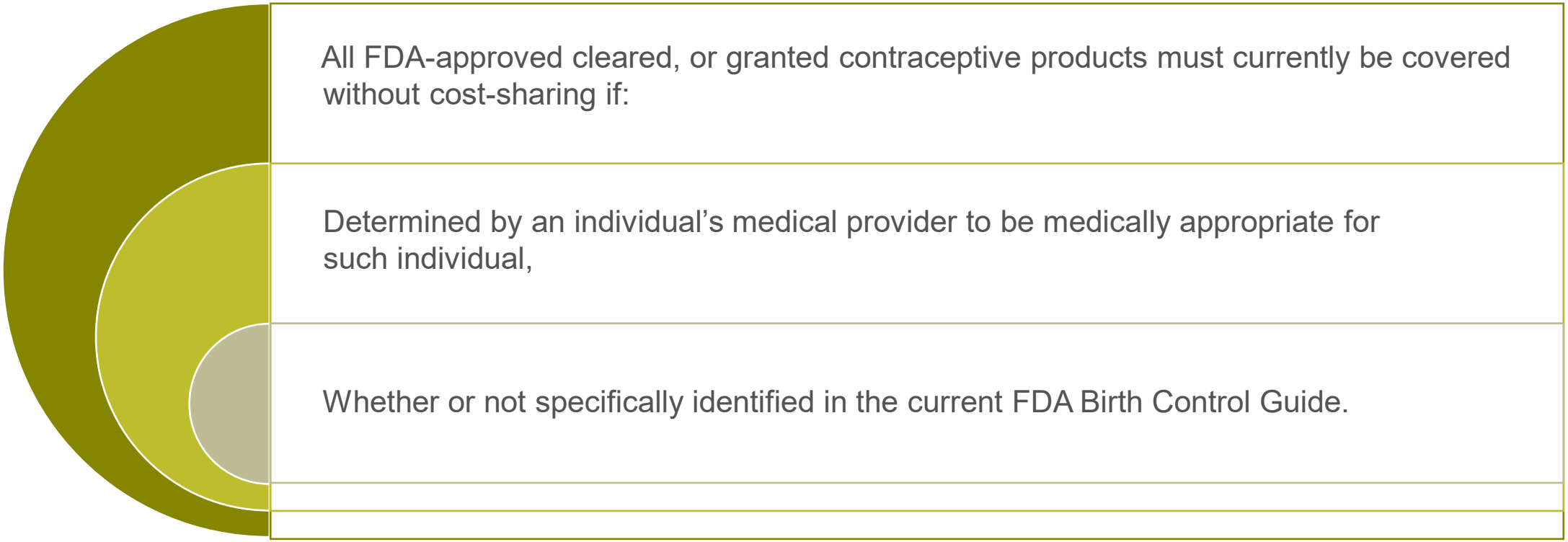
Colorectal Cancer Screening

Plan Years on or after May 31, 2022



Contraceptive Coverage

Agency Clarifications



Preventive Services Guidelines for Women

Plan Years on or after December 30, 2022

New: counseling to prevent obesity in women aged 40 to 60 with normal or overweight BMI.

Updated: Lactation support services; additional contraceptive services; Counseling for sexually-transmitted infections, additional well-women visit services.

Applies for plan years beginning on or after December 30, 2022.

Telehealth & HSAs

Ended, Then Extended, Temporary HSA Relief for Telemedicine

- The CARES Act permitted an individual to have free or reduced cost telemedicine coverage within a qualifying HDHP
  - Even before they satisfy their annual statutory minimum deductible,
  - Without negatively impacting their HSA eligibility.
- This special relief was only available for plan years beginning before January 1, 2022.
- The Consolidated Appropriations Act of 2022 (CAA 2022) extended the relief from April 1, 2022 through December 31, 2022.
- Not retroactive to January 1, 2022. Based on calendar year, not plan year.

ADA and GINA Wellness Rules

What is the Rule?

Wellness programs that have a disability-related inquiry or medical examination are subject to the ADA.

Wellness programs seek genetic information (including information about the manifestation of a disease or disorder in a family member) are subject to GINA.

There is, currently, no bright line rule on the permissible incentive for a wellness program under the ADA or GINA.

When is it Applicable?

It's unclear if or when the EEOC may issue new proposed regulations. As a result, employers sponsoring wellness programs subject to ADA or GINA have no clear guidance as to what incentive amounts are compliant.

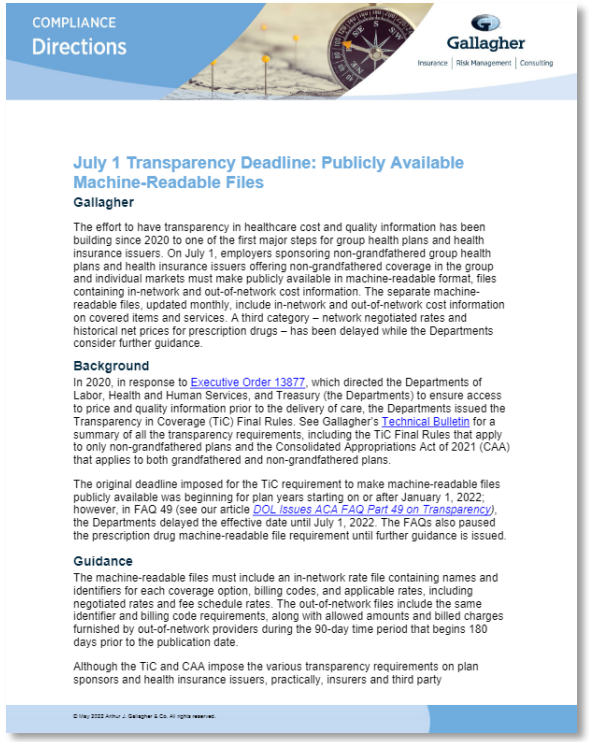
Yale University (which sponsored a wellness program aligned with the pre-vacated ADA and GINA limitations) recently agreed to a $1.29M settlement to resolve a dispute related to this matter.

Practical Tips

- Consider your wellness programs in light of this changing environment – both considering your own risk tolerance, as well as more basic questions such as how effective is the program and do employees embrace it.
- Employers should be prepared to pivot if and when the EEOC releases new guidance.

Resource Pod Recap

Machine-Readable Files



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July 1 Transparency Deadline: Publicly Available Machine-Readable Files

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The effort to have transparency in healthcare cost and quality information has been building since 2020 to one of the first major steps for group health plans and health insurance issuers. On July 1, employers sponsoring non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets must make publicly available in machine-readable format, files containing in-network and out-of-network cost information. The separate machine-readable files, updated monthly, include in-network and out-of-network cost information on covered items and services. A third category – network negotiated rates and historical net prices for prescription drugs – has been delayed while the Departments consider further guidance.

Background

In 2020, in response to Executive Order 13877, which directed the Departments of Labor, Health and Human Services, and Treasury (the Departments) to ensure access to price and quality information prior to the delivery of care, the Departments issued the Transparency in Coverage (TiC) Final Rules. See Gallagher's Technical Bulletin for a summary of all the transparency requirements, including the TiC Final Rules that apply to only non-grandfathered plans and the Consolidated Appropriations Act of 2021 (CAA) that applies to both grandfathered and non-grandfathered plans.

The original deadline imposed for the TiC requirement to make machine-readable files publicly available was beginning for plan years starting on or after January 1, 2022; however, in FAQ 49 (see our article *DOL Issues ACA FAQ Part 49 on Transparency*), the Departments delayed the effective date until July 1, 2022. The FAQs also paused the prescription drug machine-readable file requirement until further guidance is issued.

Guidance

The machine-readable files must include an in-network rate file containing names and identifiers for each coverage option, billing codes, and applicable rates, including negotiated rates and fee schedule rates. The out-of-network files include the same identifier and billing code requirements, along with allowed amounts and billed charges furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date.

Although the TiC and CAA impose the various transparency requirements on plan sponsors and health insurance issuers, practically, insurers and third party

Compliance at a Glance: Annual Calendar

January 1 Plan Year
Compliance at a Glance

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Key Dates and Actions for Plans with January 1 Plan Years

JANUARY

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DECEMBER

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2022 Key Actions

Jan. 1—Apply new indexed dollar values.

Jan. 31—Furnish Forms W-2.

Feb. 28—Meet paper filing deadline for Forms 1095.

Mar. 1—Submit a report of HIPAA privacy and security breaches discovered in the calendar year 2021 that involve fewer than 500 individuals.

Mar. 2—Furnish Forms 1095-B or 1095-C to individuals.

Mar. 2—Meet deadline for disclosure of creditable/noncreditable drug coverage to CMS.

Mar. 31—Meet deadline for electronically filing Forms 1094-B, 1094-C, 1095-B and 1095-C with the IRS.

July 29—Provide a summary of material modification (SMM) for changes made in the 2021 plan year to meet the deadline of 210 days after the end of the plan year.

July 31—File Form 5500 (or Form 5558 for 2 1/2-month extension to file Form 5500) for the plan year ending on December 31, 2021.

July 31—Pay PCORI fees for all plans.

Sept. 30—Distribute the summary annual report (SAR) (unless an extension for Form 5500 filed) to all plan participants for ERISA plans that are nonexempt.

Oct. 15—Provide the Medicare Part D notice of creditable (or noncreditable) drug coverage.

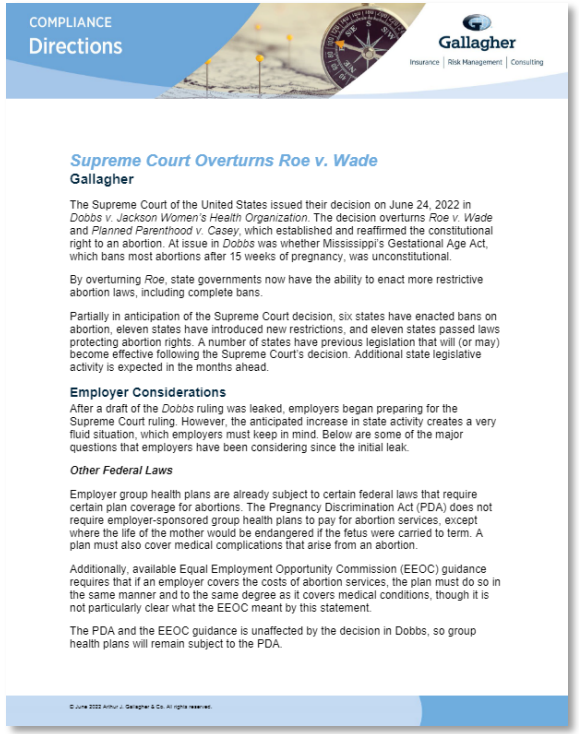
Oct. 15—File Form 5500 for plan year ending on December 31, 2021, if extension filed.

Dec. 15—Distribute SAR if extension for Form 5500 filed.

Dec. 31—Distribute the annual notices for the Women's Health and Cancer Rights Act and the Children's Health Insurance Program unless the notices were provided during annual enrollment.

Other deadlines may apply, such as notice deadlines based upon participant status or filing deadlines based upon plan status. State-specific deadlines are outside our scope.

Supreme Court Overturns Roe v. Wade



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Supreme Court Overturns Roe v. Wade

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The Supreme Court of the United States issued their decision on June 24, 2022 in *Dobbs v. Jackson Women's Health Organization*. The decision overturns *Roe v. Wade* and *Planned Parenthood v. Casey*, which established and reaffirmed the constitutional right to an abortion. At issue in *Dobbs* was whether Mississippi's Gestational Age Act, which bans most abortions after 15 weeks of pregnancy, was unconstitutional.

By overturning *Roe*, state governments now have the ability to enact more restrictive abortion laws, including complete bans.

Partially in anticipation of the Supreme Court decision, six states have enacted bans on abortion, eleven states have introduced new restrictions, and eleven states passed laws protecting abortion rights. A number of states have previous legislation that will (or may) become effective following the Supreme Court's decision. Additional state legislative activity is expected in the months ahead.

Employer Considerations

After a draft of the *Dobbs* ruling was leaked, employers began preparing for the Supreme Court ruling. However, the anticipated increase in state activity creates a very fluid situation, which employers must keep in mind. Below are some of the major questions that employers have been considering since the initial leak.

Other Federal Laws

Employer group health plans are already subject to certain federal laws that require certain plan coverage for abortions. The Pregnancy Discrimination Act (PDA) does not require employer-sponsored group health plans to pay for abortion services, except where the life of the mother would be endangered if the fetus were carried to term. A plan must also cover medical complications that arise from an abortion.

Additionally, available Equal Employment Opportunity Commission (EEOC) guidance requires that if an employer covers the costs of abortion services, the plan must do so in the same manner and to the same degree as it covers medical conditions, though it is not particularly clear what the EEOC meant by this statement.

The PDA and the EEOC guidance is unaffected by the decision in Dobbs, so group health plans will remain subject to the PDA.

Workforce Trends Report

Thank you!

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