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# 2022 Compliance Year-End Review

**THURSDAY**  
**NOVEMBER 10, 2022**

3 P.M. ET ■ 2 P.M. CT  
1 P.M. MT ■ 12 P.M. PT

## Meet Your Gallagher Speakers



**Sally Wineman, J.D.**

Area Senior Vice  
President,  
Compliance Counsel



**Kim Mitchell, J.D.**

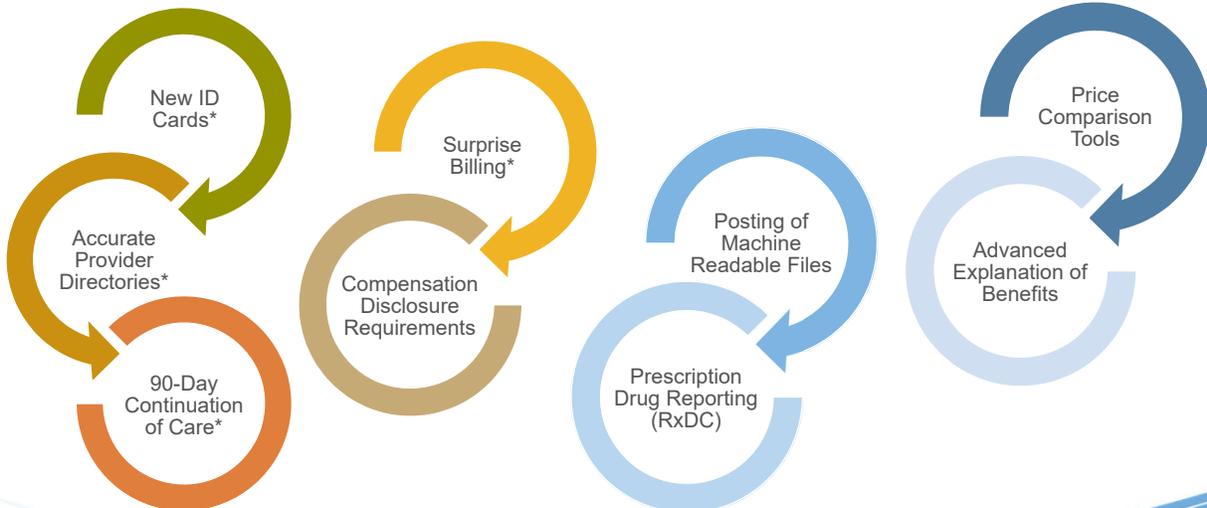
Divisional Vice President,  
Compliance Counsel



**Andrew Malahowski, J.D.**

Area Senior Vice  
President,  
Compliance Counsel

## Transparency Overview



*\* Apply good faith, reasonable interpretation of the law, pending further guidance*

# Upcoming Transparency Rules



## What's Next?

|   |   |  |
|---|---|--|
| <b>Price Comparison Tools</b><br>500 Items and Services<br>Plan Years beginning on or after January 1, 2023 | <b>Price Comparison Tools</b><br>All Items and Services<br>Plan years beginning on or after January 1, 2024 | <b>Advanced Explanation of Benefits</b><br>Delayed<br>Pending further guidance |
|---|---|--|

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# RxDC Reporting

Due by Dec. 27, 2022 and June 1<sup>st</sup> thereafter

## Who Needs to Report?

|  |   |
|--|---|
| <b>Group Health Plans</b> <ul style="list-style-type: none"><li>• All sizes</li><li>• Fully Insured and Self-Insured</li><li>• Governmental Plans</li><li>• Church Plans</li><li>• Grandfathered Plans</li></ul> | <b>Not Required:</b> <ul style="list-style-type: none"><li>• Account-based Plans – FSAs, HRAs</li><li>• Excepted benefits<ul style="list-style-type: none"><li>– Hospital Indemnity or other fixed indemnity</li><li>– Disease-specific insurance</li></ul></li></ul> |
|--|---|



NOTE: The RxDC Report is the Prescription Drug Data Collection Report.

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## RxDC Reporting - Information to Be Filed

- Two types of files must be uploaded to HIOS\*:
  - P2: Plan Information file that contain information about the plan(s); and
  - D1- D8: Data files which contain information about premiums, drug costs, and other costs

### Plan Information (P2)

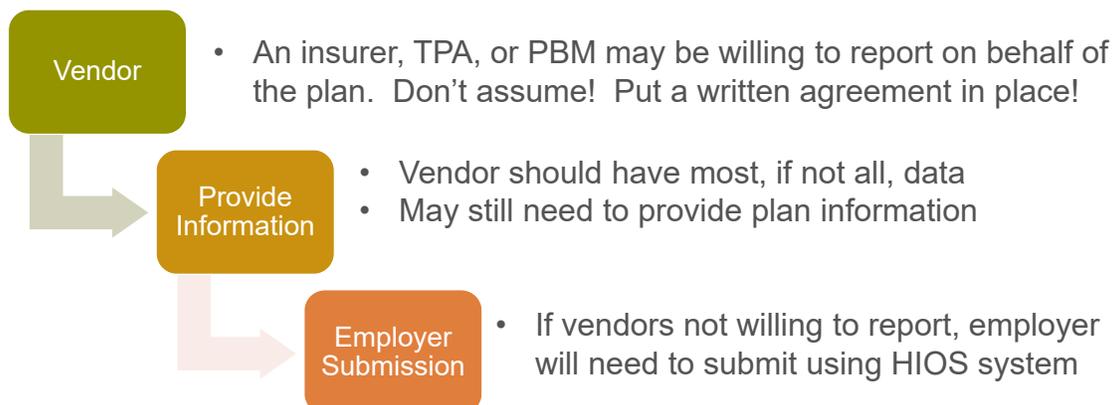
- Plan name, plan number, ERISA Form 5500 number and the HIOS number (if applicable)
- States in which the plan is offered
- Market segment
- Plan year beginning and ending dates
- Plan sponsor's name and EIN
- Insurer, TPA, and PBM names and EINs

### Data Files (D1-D8)

- D1 – Premium and life-years
- D2 – Spending by category
- D3 – Top 50 most frequent brand drugs
- D4 – Top 50 most costly drugs
- D5 – Top 50 drugs by spending increase
- D6 – Rx totals
- D7 – Rx rebates by therapeutic class
- D8 – Rx rebates for the top 25 drugs

\* Information will be submitted through the RxDC module in the Health Insurance Oversight System (HIOS) that is on the CMS Enterprise Portal

## RxDC – Submitting Plan Information



## RxDC – Submission Process

- 1 • Create an EIDM account in the CMS Enterprise Portal
- 2 • Request access to HIOS with the CMS Enterprise Portal
- 3 • Register your organization
- 4 • Request a role for the RxDC module in HIOS
- 5 • Submit your RxDC files

Don't delay.  
It can take up to  
2 weeks!

## RxDC Reporting Challenges

- Employers will want Insurer, TPA and/or PBM to handle the detailed reporting, **BUT** don't assume!
  - You may still need to provide plan information for them to complete reporting
  - They may prefer to provide you the data to directly submit
  - Or, they may file their data and let you file your plan information
  - **Watch** for any vendor deadlines to provide plan information.
    - **Don't miss those deadlines** or you could end up needing to file all the data files directly!

# RxDC – Reporting Challenges



- **Mid Year Renewal:** Reporting is done on a calendar year basis, so you may need to deal with multiple vendors
  - First report includes CY 2020 and 2021
  - 2022 Reporting due June 1, 2023 for all plans
- **Carrier Change:** Changing Insurers, TPAs, or PBMs at renewal
  - Prior vendor still providing report data for you?
  - New written agreement with new vendor
- **Service Charge:** Any additional administrative charges for reporting?

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# GBS Resources



**COMPLIANCE DIRECTIONS**

**Fourth Quarter Transparency To-Do List**  
Gallagher

As part of the Patient Protection and Affordable Care Act (ACA) and the Consolidated Appropriations Act of 2021 (CAA), various requirements have taken effect in 2022 that make up the Transparency rules. All group health plans are required to comply with the CAA Transparency requirements, while only non-grandfathered group health plans are required to comply with the ACA portion of the Transparency rules. Keeping track of what's coming next and how to prepare can be difficult. Gallagher has prepared the below summary and tips to help employers prepare for the next phase of Transparency.

**Background**  
The ACA Transparency rules require non-grandfathered group health plans to comply with two requirements: (1) to post machine-readable files, updated monthly, to the public website of the plan by July 1, 2022, and (2) to make personalized cost information available for the first 500 defined services by January 1, 2023 and for all covered services by January 1, 2024. There is a requirement for a third file with information on prescription drugs that is delayed indefinitely pending future guidance. The CAA Transparency rules require all group health plans (both grandfathered and

**RxDC Registration and Submission Guides**

All group health plans must report specific information about prescription drug and healthcare spending on an annual basis. The reports are submitted in the Prescription Drug Data Collection (RxDC) Module of the CMS Health Insurance Oversight System (HIOS). CMS has provided guidance, forms, and instructions for using HIOS and the RxDC Module. The following will be helpful in the RxDC process. As the first reports are due December 27, 2022, CMS has been regularly updating their guides and HIOS.

**Prescription Drug Data Collection (RxDC): Files P2 and D1 Explanations**

Prescription Drug Data Collection (RxDC) reports to the Centers of Medicare and Medicaid Services (CMS) is a required part of the transparency rules enacted under the Consolidated Appropriations Act of 2021 (CAA). The initial reports for reference (i.e. calendar years 2020 and 2021) are due on December 27, 2022. Then, on an annual basis each June 1, reports will be due for the preceding calendar year. Gallagher's *Prescription Drug Reporting Summary* provides an overall description of the requirement and information to be reported to CMS.

All group health plans must report – grandfathered, non-grandfathered, fully insured, and self-insured, including level-funded plans. The RxDC reporting consists of multiple comma-separated value (CSV)-formatted files. The parties that will report the files are called "reporting entities." For employer-sponsored plans, files P2 and D1-D6, and a Narrative Response, if applicable, must be submitted into CMS Health Insurance Oversight System (HIOS).

- Fully insured plans: Insurers will most likely report all files for fully insured group health plans. Plan sponsors may enter into a written agreement with the insurer obligating the insurer to submit the report. However, plan sponsors should seek confirmation from the insurer and proof of submission for recordkeeping purposes.
- Self-insured plans (including level-funded plans): Plan sponsors may enter into a written agreement with the TPA and/or PBM to report on behalf of the plan; however, self-insured plan sponsors remain liable for fulfilling the requirement. TPAs and PBMs will likely report at least some of the files, but they might not report all of them. For example, many TPAs and PBMs will report files D2-D8 but might not report D1. Plan sponsors should confirm which of the files the TPA and/or PBM will report, obtain written confirmation of those obligations, and retain proof of those submissions by the third parties for recordkeeping purposes.

Gallagher has developed this resource with snapshots of the P2 and D1 files with definitions and tool to assist employers in

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# Pandemic Relief – Potential Sunset

Plan administrators continue a “watchful waiting” approach

**Public Health  
Emergency**

Effective October 13, 2022, HHS extended the Public Health Emergency (first effective on January 27, 2020). The extension lasts another 90 days, though HHS has previously indicated it will provide a 60-day advance notice if the emergency will not be extended again.

**National  
Emergency**

Effective March 1, 2022, President Biden extended the National Emergency Declaration (first made in 2020). The National Emergency lasts for one year after the extension is effective (until February 28, 2023) unless the President further extends it or terminates it earlier.

These federal declarations impact the timing of certain mandates on group health plans, and other forms of relief for group health plan participants.

# COVID-19 Vaccines and Testing

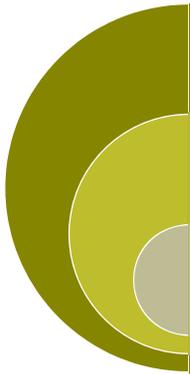
Reminder of the Rules Currently In Place

| Coverage of COVID-19 Tests  | Coverage of COVID-19 Vaccines  | HSAs, HRAs, FSAs   |
|---|--|--|
| Pursuant to FFCRA and the CARES Act, group health plans must cover COVID-19 tests without cost-sharing. | Pursuant to the CARES Act, non-grandfathered group health plans must cover COVID-19 vaccines without cost-sharing. | COVID-19 tests are qualifying medical expenses that can be reimbursed by HSAs, HRAs, and FSAs (if not already paid by another source). |
| January 2022 guidance expanded this mandate to include over-the-counter tests.                          | This includes booster doses for certain individuals, consistent with the EUA or BLA.                               | HDHPs can cover COVID tests without cost-sharing without spoiling HSA eligibility.   |

# COVID-19 Vaccines and Testing



## What happens when the Public Health Emergency expires?



COVID-19 Vaccines: since COVID-19 vaccines are already established as a recommended preventive health service, plans must continue to cover the vaccine without cost-sharing after the PHE expires.

COVID-19 Tests: when the PHE expires, plans are no longer required to cover tests or test administration without cost-sharing.

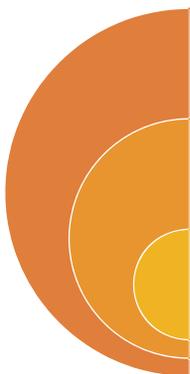
Other Nuances: federal government payment of vaccine costs may end eventually; HSA compatibility remains in place.

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# Outbreak Period Extensions of Time



## In effect during the National Emergency



Affected time frames are COBRA elections (60 days); COBRA payment grace periods (45 or 30 days); certain participant COBRA notification obligations; HIPAA Special enrollment (30 or 60 days); claims and appeal deadlines.

The time frame is "disregarded" until the earlier of (a) 1 year, or (b) 60 days after the announced end of the National Emergency.

On the applicable date, the timeframes for individuals and plans with periods that were previously disregarded under will resume. In no case will a disregarded period exceed 1 year.

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## End of Outbreak Period

### Example #1 – COBRA Election

- Covered employee experiences a COBRA qualifying event on October 1, 2021
  - Under normal COBRA rules, the qualified beneficiary would have 60 days to elect COBRA.
  - The normal deadline under COBRA would be **November 30, 2021**.
- The Outbreak Period relief provides a maximum of one year (beyond the normal deadline) to elect COBRA, until **November 30, 2022**.
- If the National Emergency expires on **February 28, 2023**, then this has no effect on this individual's extended COBRA election deadline (though later COBRA payment deadlines might be effected).

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## End of Outbreak Period

### Example #2 – COBRA Payment Grace Period

- Qualified Beneficiary has a monthly COBRA premium payment that is due on July 1, 2022
  - Under normal COBRA rules, the qualified beneficiary would have a 30-day grace period to make this payment.
  - Normally, the grace period would expire on **July 31, 2022**.
- The Outbreak Period relief provides a maximum of one year (beyond the normal deadline) to pay for COBRA, until **July 31, 2023**.
- However, if the National Emergency expires on **February 28, 2023**, then the 30-day grace period to pay for COBRA will resume 60 days after that expiration, on April 29, 2023, resulting in an expiration of the grace period to pay this COBRA premium payment on **May 29, 2023**.

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# End of Outbreak Period

## Example #3 – HIPAA Special Enrollment

- Employee is married on October 1, 2022
  - This is a HIPAA special enrollment event that would normally provide the employee with 30 days to elect coverage for their spouse.
  - The normal deadline under HIPAA would be **October 31, 2022**.
- The Outbreak Period relief provides a maximum of one year (beyond the normal deadline) to elect HIPAA special enrollment, until **October 31, 2023**.
- However, if the National Emergency expires on **February 28, 2023**, then the 30-day timeframe to elect HIPAA special enrollment will resume 60 days after that expiration, on April 29, 2023, resulting in a special enrollment deadline of **May 29, 2023**.



# Reproductive Benefits

## Applicable Law

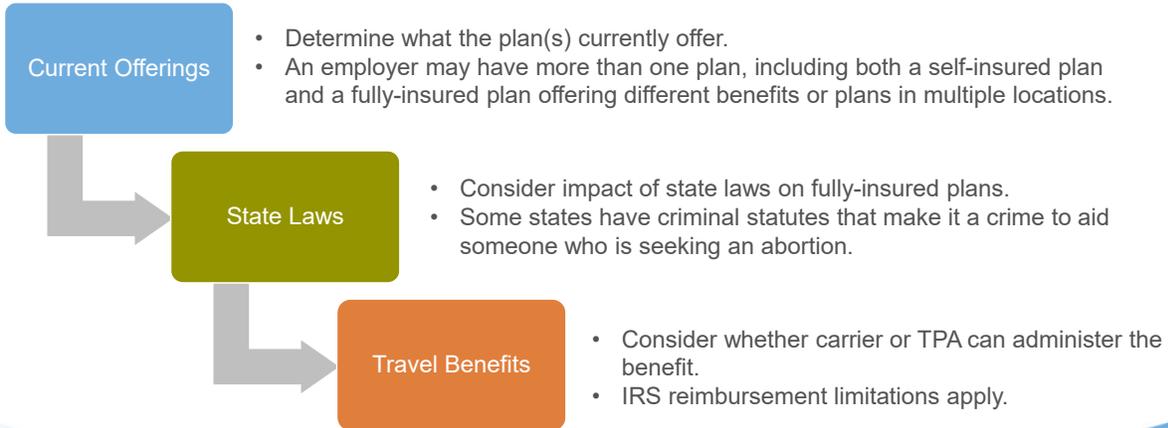


Both the PDA and the EEOC guidance are unaffected by the Supreme Court ruling, meaning.....

Group health plans remain subject to both

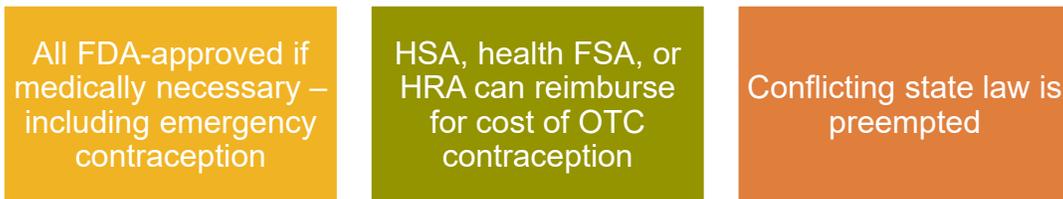
# Reproductive Benefits

## Employer Considerations



# Preventive Services

## Contraceptive Coverage



# Preventive Services



## Guidelines for Women

### New:

- Counseling to prevent obesity

### Updated:

- Lactation support
- Contraceptives
- Counseling for STIs
- HIV screening
- Well-women visits

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

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# Preventive Services



## Colorectal Cancer Screening

Follow-up colonoscopy must be covered in certain cases

Extended age to include age 45 to 49 for recommended screening

Applies for plan years beginning on or after May 31, 2022

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## 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
  - Before the annual statutory minimum deductible is satisfied,
  - 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.



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## “Family Glitch” Fix

- Spouse and dependent eligibility to receive subsidies for ACA marketplace coverage will be based on the affordability of offer of family coverage through employer group health plan
- Does not affect employer’s obligation under the ACA employer mandate
- IRS guidance created new permitted mid-year election change for cafeteria plans. Employers may amend their Section 125 plan to allow participants to drop family coverage for spouses and/or dependent children to enroll in ACA marketplace coverage
- Both sets of rules are effective January 1, 2023
- Employers adopting the newly available mid year election change events must amend their plans by the end of the plan year in which it is first allowed



26

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## Year-End Reminders

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## Year-End Reminders

### Employer Shared Responsibility Mandate

| Mandate   | 2022                | 2023                            |
|---|---------------------|---------------------------------|
| Affordability Rate  | 9.61%               | 9.12%                           |
| Employer Shared Responsibility Assessment - "Headcount" (4980H(a))      | \$2,750             | \$2,880                         |
| Employer Shared Responsibility Assessment - "Individualized" (4980H(b)) | \$4,120             | \$4,320                         |
| FPL Safe Harbor - Maximum Self-Only Contribution                        | \$103.15 (CY Plans) | <b>\$103.28 est.</b> (CY Plans) |

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# Year-End Reminders



## ACA Cost Sharing and Deductibles

| Deductibles & Out-of-Pocket Maximums | 2022<br>Single/Family | 2023<br>Single/Family   |
|--------------------------------------|-----------------------|-------------------------|
| ACA Out-of-Pocket Maximum*           | \$8,700/\$17,400      | <b>\$9,100/\$18,200</b> |
| HDHP Minimum Deductible              | \$1,400/\$2,800       | <b>\$1,500/\$3,000</b>  |
| HDHP Out-of-Pocket Maximum           | \$7,050/\$14,100      | <b>\$7,500/\$15,000</b> |

\* Applicable to Non-Grandfathered Plans

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# Year-End Reminders



## IRS Adjustments to Account-Based Plans

| Contributions                              | 2022<br>Single/Family                             | 2023<br>Single/Family   |
|--|---|---|
| HSA Annual Contribution Limit              | \$3,650/\$7,300                                   | <b>\$3,850/\$7,750</b>  |
| HSA Catch-Up Contribution (age 55 or over) | \$1,000   | <b>\$1,000</b>  |
| Health FSA Contribution Limit              | \$2,850   | <b>\$3,050</b>  |
| Health FSA Carryover Limit                 | \$570   | <b>\$610</b>  |
| Dependent Care Contribution Limit          | \$5,000<br>(\$2,500 if married filing separately) | <b>\$5,000</b><br><b>(\$2,500 if married filing separately)</b> |

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# Upcoming Year Outlook

## Items to Watch in 2023

- Wellness - Rules yet to come
- Transparency - Advanced EOB rules
- HSA Telehealth extension for 2023
- Mental Health Parity – Additional guidance
- Mid-term election impacts
- State legislative activity impacts
- DOL – Proposed Independent Contractor rules
- Will we see the end of the Public Health and National Emergency for COVID-19?



31

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# What Else Is New?



Changes in your organization may create legal obligations that are “new to you”

Mergers and Acquisitions

Employer Shared Responsibility Obligations

Moving From Fully-Insured to Self-Insured

Implementing New Benefit Designs

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# Resources



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WEBINAR

## Practically Speaking with Compliance

Insurance | Risk Management | Consulting

## Back to Basics with Compliance

2022

Employers are searching for talent in human resources and employee benefits, and often the right person for the job has the skills to perform, but needs basic or refresher training to put them on track for success.

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