AUGUST 2022

SSG COMPLIANCE RECAP

What every HR leader should know about compliance.

STRATEGIC SERVICES GROUP

August was a busy month, with employers buzzing about transparency, reporting, and more. As we wrap up the summer season of the 2022 benefits compliance calendar, be mindful of these important issues.

2023 ACA Facts and Figures

The Affordable Care Act (ACA) imposes an employer shared responsibility payment (ESRP) on any applicable large employer (ALE) that offers qualifying coverage to its full-time employees but for which the employee share of the cost for the lowest tier self-only coverage option is deemed to be unaffordable. The ACA bases affordability on an employee's household income and indexes the percentage annually for inflation. For 2023, the affordability threshold is 9.12% – a drop from 2022. ALEs preparing for 2023 should be aware that this drop will affect how much they can charge employees for health coverage and still avoid an ESRP.

An ALE typically will not know an employee's overall household income, so federal regulators created three safe harbors an ALE may use to judge whether an offer of coverage is affordable.

- The W-2 Safe Harbor generally is based on the wages paid to the employee that the employer reports in Box 1 of that employee's Form W-2.
- The Rate of Pay Safe Harbor generally is based on an employee's rate of pay at the beginning of the coverage period, with adjustments permitted for an hourly employee, if the rate of pay is decreased (but not if the rate of pay is increased).
- The Federal Poverty Line Safe Harbor generally treats coverage as affordable for a month if an employee's required contribution for the month does not exceed 9.5%, adjusted annually, of the federal poverty level (FPL) for a single individual for the applicable calendar year, divided by 12. The maximum employee contribution for lowest tier self-only coverage for ALEs with plan years starting before July 2023 (including calendar year plans) will be $103.28.

For the 2022 reporting cycle, ALEs must furnish individual statements to full-time employees no later than March 2, 2023. ALEs must file applicable reports with the IRS no later than February 28, 2023, if filing by paper, or no later than March 31, 2023, if filing electronically (mandatory for ALEs required to file more than 250 W-2s in the prior calendar year).

IN THIS ISSUE

Departments Issue Final Rules to Clarify Dispute Resolution and Transparency Under No Surprises Act

On August 19, the U.S. Departments of Health and Human Services, Labor, and the Treasury (the Departments) released final rules regarding the No Surprises Act provisions of the Consolidated Appropriations Act, 2021. The rules address the No Surprises Act's required independent dispute resolution (IDR) process and finalize prior interim final rules relating to information that group health plans and health insurance issuers must share about the qualifying payment amount (QPA) – the median of a plan or insurer's in-network rates for the item or service in the relevant geographic region – used to determine disputed out-of-network covered expenses.

Interim final rules issued in October 2021 required that certified IDR entities select the offer closest to the QPA, unless the certified IDR entity determined that any additional credible information submitted by the parties demonstrated that the QPA was materially different from the appropriate out-of-network rate. A federal District Court later vacated this requirement in multiple 2022 rulings. The final rules remove the provisions that the District Court vacated.

The final rules specify that certified IDR entities should select the offer that best represents the value of the item or service under dispute after considering the QPA and all permissible information submitted by the parties. So, certified IDR entities must consider the QPA and then must consider all additional permissible information submitted by each party to determine which offer best reflects the appropriate out-of-network rate. The additional information may not include information prohibited by the statute.

Additionally, when a plan or issuer changes a provider or facility's service code used for billing purposes to one of lesser value – which would reduce the payment to the provider or facility – the plan or issuer must now provide additional information for this "downcode" process.

The final rules also require that the written decision explain the information used and relied on by the certified IDR that demonstrated the selected offer is the out-of-network rate that best represents the value of the item or service.

Employers Should Prepare to Issue Medicare PART D Notices

Medicare Part D letters of creditable coverage are due on October 15 to all Medicare Part D eligible individuals who are covered under or who apply for a plan's prescription drug coverage. The Medicare Part D notice informs individuals about the plan's prescription drug coverage status for the next calendar year. For Medicare-eligible individuals to make informed and timely enrollment decisions, group health plan sponsors must disclose the status (creditable or non-creditable) of the plan's prescription drug coverage before the annual Medicare enrollment period begins on October 15 each year.

Knowing a prescription drug plan's creditable status allows an individual to make an informed choice whether to enroll in a Medicare Part D prescription drug plan. Moreover, an individual who does not have creditable prescription drug coverage and who does not elect Medicare Part D before the end of the initial Medicare enrollment period must pay higher premiums if they enroll later in Medicare Part D. So, knowing the creditable status of an employer's drug coverage will help avoid costly penalties.

Employers should determine whether their health plans' prescription drug coverage is creditable for the upcoming calendar year and distribute Medicare Part D notices before October 15. Employers that distribute open enrollment materials prior to October 15 can include Medicare Part D notices with other required health plan notices. Employers with open enrollment starting October 15 or later will need to send a separate Medicare Part D notice before October 15.

Plan Sponsors Should Prepare for Substantial Medical Loss Ratio Rebates in 2022

According to The Kaiser Family Foundation, insurance carriers are projected to issue approximately $275 million in rebates to small group policyholders, and $168 million to large group policyholders. Plan sponsors should be prepared to handle any medical loss ratio (MLR) rebates according to applicable rules.

The Affordable Care Act (ACA) requires health insurers in the small group market to spend 80% on medical care, and insurers in the large group market must spend 85% on medical care. The MLR rule does not apply to self-funded health plans or stop-loss insurance policies.

The ACA dictates that insurers not meeting the MLR standard must refund the excess premiums to their policyholders, either as cash refunds (rebates) or as a credit on the employer's premium statement. Employers that receive a rebate must handle the funds appropriately, based on whether the Employee Retirement Income Security Act of 1974 (ERISA) applies to the plan.

Under the U.S. Department of Labor's (DOL) guidance, employers are generally prohibited from retaining a rebate amount greater than the total amount of premiums and other plan expenses paid by the employer. The DOL has approved the following methods for distribution:

- Distributed to participants under a reasonable, fair, and objective method.
- If distributing payments to participants is not cost-effective because the amounts are small or would have negative tax effects on affected participants, the employer may utilize the rebate for other permissible plan purposes, such as applying the rebate toward future participant premium payments or toward benefit enhancements.

The Internal Revenue Service (IRS) has issued a set of FAQs to explain the tax treatment of MLR rebates. In general, a cash refund to an employee would create a taxable event unless the employee had previously contributed the funds on an after-tax basis. For this reason, employers should avoid issuing cash refunds to participants except upon advice of legal counsel.

Employers should maintain records to detail how it determined the MLR rebate payable to eligible plan participants and exactly who benefitted. Finally, employers should seek advice from outside counsel to help determine how to properly use any MLR rebate.

Blue Cross Blue Shield Association Antitrust Settlement Status

The settlement has been reached in the class action antitrust lawsuit on behalf of individuals and companies that purchased or received health insurance provided or administered by a Blue Cross Blue Shield company.

The settlement received final approval on August 9, 2022. To receive a payment, you must have filed a claim by November 5, 2021. A distribution timeline is not currently available. Visit the Blue Cross Blue Shield Settlement website for updates.

Health Plan Disclosure Requirements for Prescription Drugs

Under the Affordable Care Act (ACA) transparency-in-coverage (TiC) rules and provisions of the Consolidated Appropriations Act, 2021 (CAA), group health plan sponsors must both disclose and report detailed information regarding a plan's prescription drug coverage and costs.

The annual report (Report) to the Centers for Medicare & Medicaid Services (CMS) deadline was originally set for last year, but the Departments that enforce the rules delayed the deadline until December 27, 2022. Also, because there is significant overlap in the rules regarding prescription drug costs, the Departments delayed the prescription drug machine-readable file (MRF) requirement indefinitely pending further regulation and guidance.

Plans (or their carriers or another third party) will file Reports through the CMS's RxDC module in the Health Insurance Oversight System (HIOS). A plan sponsor will need to coordinate with a carrier or other vendor who already has HIOS access or will need to apply for its own credentials and access.

Plans generally must provide:

- Plan name and number
- Plan sponsor and principal place of business
- Plan year start and end dates
- Number of participants, beneficiaries, or enrollees
- Each state in which the plan is offered
- The 50 most frequently dispensed brand name prescription drugs, and the total number of paid claims for each
- The 50 most costly prescription drugs by total annual spending
- The annual amount spent by the plan for each such drug
- The 50 prescription drugs with the greatest increase in plan expenditures from the plan year preceding the reported plan year, and, for each such drug, the change in amounts expended by the plan in each such plan year
- Total spending on health care services by the plan broken down by the type of costs, including:
- Hospital costs
- Health care provider and clinical service costs, for primary care and specialty care separately
- Costs for prescription drugs
- Other medical costs, including wellness services
- Spending on prescription drugs by plan and by participants, beneficiaries, and enrollees
- The average monthly premiums paid by participants, beneficiaries, and enrollees and paid by employers on behalf of participants, beneficiaries, and enrollees
- Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or its administrators or service providers, including the amount paid for each therapeutic class of drugs and for each of the 25 drugs that yielded the highest amounts of rebates and other remuneration under the plan from drug manufacturers during the plan year
- Any reduction in premiums and out-of-pocket costs associated with these rebates, fees, or other remuneration

The Departments have announced that they will not take enforcement action related to the requirement to report average monthly premium paid by employers versus members for the 2020 and 2021 reference years if that data is reported in the RxDC report for the 2022 reference year and all future reference years.

Plan sponsors should already be working to have a process in place to meet the December 27, 2022, deadline for reporting prescription drug information to CMS through the HIOS system.

Inflation Reduction Act

On August 16, President Biden signed the Inflation Reduction Act (IRA) into law. The legislation addresses deficit reduction, investments in healthcare, domestic energy, climate change, and other issues. The provisions impacting Medicare are meaningful, as they specifically allow the Centers for Medicare & Medicaid Services (CMS) to negotiate prices with manufacturers for certain high-cost drugs.

Additionally, the Act:

- Adds a $2,000 cap on Medicare Part D out-of-pocket spending
- Limits premium increases on Medicare Part D
- Requires pharmaceutical manufacturers to pay rebates if prices rise faster than inflation
- Limits the cost of insulin
- Eliminates cost-sharing for adult vaccines covered under Medicare Part D

Employers have no actionable items on this legislation.

Question of the Month

Q: Do the surprise billing provisions of the No Surprises Act apply in the case of a group health plan or group or individual health insurance coverage that generally does not provide out-of-network coverage?

A: Yes. The No Surprises Act's protections regarding emergency services, non-emergency services furnished by a nonparticipating provider for a visit to a participating facility, and air ambulance services apply if those services are otherwise covered under the plan or coverage, even if the plan or coverage otherwise does not provide coverage for out-of-network items or services.

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