SEPTEMBER 2022

# SSG COMPLIANCE RECAP

What every HR leader should know about compliance.

STRATEGIC SERVICES GROUP

September was a relatively quiet month in the compliance space as employers continue the ramp-up to open enrollment.

## Prescription Drug Cost Reporting

With a due date of December 27, 2022, prescription drug cost reporting is looming large in employers' minds. The first reports for submission to the U.S. Departments of Health and Human Services, Labor, and the Treasury (the "Departments") will include data from calendar years 2020 and 2021. Required data will include the plan's prescription drug usage, including the most frequently dispensed, the most expensive, and those with the greatest increase in cost, among others. **Download the full reporting instructions** from the Centers for Medicare & Medicaid Services website.

Fully insured groups may contract with their insurance carriers to provide reporting on their behalf, while self-funded plans may contract with their third-party administrator (TPA) and pharmacy benefit manager (PBM). In all cases, the employer may be responsible for reporting certain data elements.

## 2023 Affordable Care Act Reminders For Applicable Large Employers

The Affordable Care Act (ACA) includes numerous requirements for applicable large employers (ALEs) to meet to maintain compliant group health plans. Many of these requirements change annually, so we provide this overview of the key facts and figures to keep in mind for 2023.

***Affordability Threshold***

The ACA imposes an employer shared responsibility payment (ESRP) on any 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 decrease from 2022. ALEs preparing for 2023 should be aware that this new threshold will affect how much they can charge employees for health coverage and still avoid an ESRP.

### IN THIS ISSUE



## Upcoming Deadlines

**Oct. 14**
Deadline to send Medicare Part D creditable/non-creditable coverage letters

**Oct. 15**
Form 5500 filing extension deadline

**Dec. 15**
Summary Annual Report due if Form 5500 was filed under an extension

**Dec. 27**
Prescription drug price reporting due to Centers for Medicare & Medicaid Services

***Affordability Safe Harbors***

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.

1. 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.
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).
3. 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 line (FPL) for a single individual for the applicable calendar year, divided by 12. Note that the government typically does not release the FPL table until after the calendar year starts. So, the rules allow many employers (including any who sponsor a calendar year plan) to use the FPL table published within the six months prior to the start of the plan year. Thus, 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.

***ESRP Penalty Amounts***

Each year the IRS announces the inflation-adjusted amounts that it will assess against any ALE that either fails to make an offer of group health coverage to at least 95% of its full-time employees (the "A penalty") or makes an offer of coverage that is either unaffordable or does not meet the ACA's minimum value standard (the "B penalty"). For 2023, the A penalty is $2,880 ($240/month), and the B penalty is $4,320 ($360/month).

***ALE Form 1094-C/1095-C Deadlines***

ALEs must annually issue individual statements (generally copies of Form 1095-C) and file Forms 1094-C and 1095-C with the IRS to disclose certain information about the group health coverage they offer their full-time employees. 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 (which is mandatory for ALEs required to file more than 250 W-2s in the prior calendar year).

## Departments Issue No Surprises Act FAQ and Clarify Independent Dispute Resolution Process

The U.S. Departments of Health and Human Services, Labor, and the Treasury (the "Departments") recently released final rules regarding the No Surprises Act. The rules specifically address required independent dispute resolution (IDR) of certain claims and expenses and finalize prior interim final rules relating to information that group health plans must disclose.

***Federal IDR Process***

The No Surprises Act required regulators to develop an IDR process to resolve conflicts between payers and providers regarding out-of-network expense amounts. Any disputes unresolved after 30 days of negotiating can be referred by either side to binding arbitration from a certified IDR entity. The IDR entity will consider the qualified payment amount (QPA) – the insurance plan's median contracted rate for the same or similar service in an area – and other relevant submitted information, and then select one side's suggested payment amount.

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. 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 interim final rules required plans and issuers to disclose the QPA for each item or service to providers and facilities with each initial claim payment or denial notice. Also, when a plan or issuer changes a provider or facility's service code to one of lesser value, the plan or issuer must now provide additional information for this process which is known as "downcoding."

The new rule states that if a QPA is downcoded, the plan or issuer has to issue with payment or denial a statement that the payer downcoded the service code or modifier billed by the provider, facility, or provider of air ambulance services. This statement also must explain the downcoding and disclose what the QPA would have been had the downcoding not occurred.

***Written IDR Determinations***

The interim final rules also required certified IDR entities to explain their payment determinations and reasoning in writing. The final rule requires an IDR entity to detail the information upon which it deemed the amount it selected is the amount that best represents the value of the out-of-network item or service. The certified IDR entity must also explain why it felt the QPA did not reflect any additional information used to select an offer.

***Plan Transparency Disclosure Rules***

The No Surprises Act requires plans and issuers to post a notice about patient protections and balance billing requirements on their websites. Plans and insurers must also disclose this information on explanations of benefits for covered items or services. The FAQs confirm group health plan sponsors without their own public health plan website can satisfy this requirement if a TPA or insurer agrees in writing to post the information on its website.

The FAQs also clarify that a group health plan sponsor can satisfy the related transparency in coverage requirement to post machine-readable files (MRF) regarding plan costs and allowed charges if a service provider agrees in writing to post the information on its website on behalf of the plan. If a plan maintains a public website, it must still post a link back to the provider's website.

***Air Ambulance Providers***

The FAQs affirm that the No Surprises Act does not mandate that plans and insurers covering only emergency air ambulance services also cover air ambulance services for non-emergencies like transporting a patient between two facilities. If a plan covers services for air ambulance, the No Surprises Act requires the same out-of-network services to be covered, but it does not require non-emergency services to be covered.

The FAQs further state that patients are protected from out-of-network bills from air ambulance companies even with a non-U.S. pickup point. Plans and insurers must use a reasonable method to determine the geographic region, including by basing the geographic region on the border point of entry to the United States after patient pickup.

***Behavioral Health Facilities***

Th FAQs also state the No Surprises Act covers emergency services rendered at an out-of-network behavioral health facility during a behavioral health crisis. The new rule provides that such services are captured by the law if provided at a facility licensed by the applicable state to provide such services, regardless of whether it is licensed as an emergency department or facility.

## ACA Preventive Services Come Into Question

A federal Judge in Texas ruled in favor of two employers and a handful of employees when they sued the U.S. Departments of Labor, Health and Human Services, and the Treasury on religious grounds asserting that the requirement to cover the pre-exposure prophylaxis (PrEP) violated their rights under the **Religious Freedom Restoration Act of 1993 (RFRA)**. The plaintiffs also brought into question the appointment process for members of the entities involved in deciding which no-cost preventive services are covered.

Group health plans under the ACA provide no-cost coverage of preventive services in four areas.

1. **U.S. Preventive Services Task Force (USPSTF)** rates evidence-based items or services with a rating of "A" or "B," including PrEP for the prevention of HIV.
2. **Advisory Committee on Immunization Practices (ACIP)** of the Centers for Disease Control and Prevention recommends routine immunizations.
3. **Health Resources and Services Administration (HRSA)** supports guidelines for preventive care and screenings for children through age 21.
4. **HRSA** also provides guidelines for preventive care and screenings for women.

There has been no remedy provided at the time of this writing, therefore the first dollar coverage for ACA preventive services remains in effect.

## Question of the Month

**Q: Do the surprise billing provisions of the No Surprises Act apply to a group health plan or group or individual health insurance coverage that does not have a network of providers, such as a plan that utilizes reference-based pricing?**

A: Yes, with respect to emergency services and air ambulance services. The provisions that limit cost sharing for out-of-network emergency services apply if a plan or issuer provides or covers any benefits for emergency services and the services are provided by a nonparticipating provider or nonparticipating emergency facility. Similarly, the provisions that limit cost sharing for out-of-network air ambulance services apply if a plan or issuer provides or covers any benefits for air ambulance services and those services are provided by a nonparticipating provider of air ambulance services. The definitions of nonparticipating provider or nonparticipating emergency facility and the protections afforded to participants, beneficiaries, or enrollees related to emergency services and air ambulance services are not dependent on whether the group health plan or group or individual health insurance coverage has a network of providers.

The provisions that limit cost sharing for non-emergency services apply only to services provided by a nonparticipating provider with respect to a visit to a participating health care facility. Therefore, as stated in the preamble to the July 2021 interim final rules, the provisions that limit cost sharing for non-emergency services provided by nonparticipating providers with respect to a visit to certain participating facilities would never be triggered if a plan or coverage does not have a network of participating facilities.

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