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Aflac | Federal Relations Advisory

2022-2023
Health benefits year in review and what's ahead

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This advisory begins with key developments to be aware of for 2023 and then provides a high-level review of 2022 developments.

COVID-19 public health and national health emergencies end May 11, 2023

The Biden Administration has announced that both the COVID-19 public health and national health emergencies end May 11, 2023. These emergencies were originally brought about to address conditions of the COVID-19 pandemic.

Plan sponsors need to understand and be ready for the changes that will occur when these emergencies end. For example:

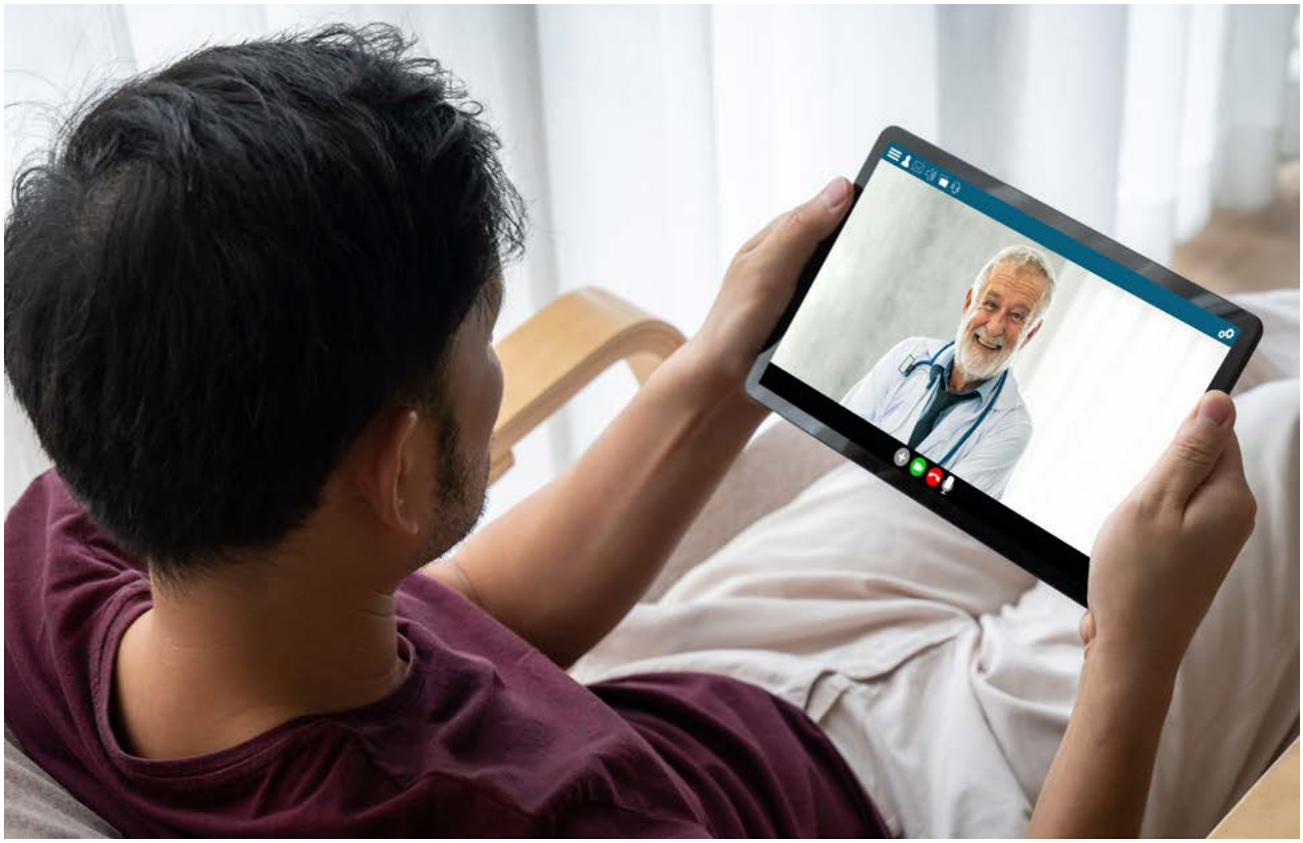
- Group health plans will no longer be required to cover over-the-counter COVID-19 tests without cost-sharing.
- Out-of-network COVID-19 vaccines will not have to be covered without cost-sharing; however, plans subject to the Affordable Care Act (ACA) preventive health requirements will still have to cover such vaccines when provided in-network.
- A variety of other requirements applicable to all ERISA-covered health plans are also impacted, including the tolling of certain deadlines during the "Outbreak Period" tied to the national emergency, such as COBRA election periods, COBRA premium payment deadlines, HIPAA Special Enrollment periods, and claims filing and appeals deadlines.

Telehealth safe harbor for high deductible health plans (HDHPs) extension

The Consolidated Appropriations Act, 2023 (CAA 23), enacted in December 2022, extends the safe harbor that permits HDHPs to cover telehealth services pre-deductible without disqualifying individuals from health savings account (HSA) eligibility. The extension is effective for plan years beginning on or after Jan. 1, 2023, and before Jan. 1, 2025.

Note that this effective date may present some administrative issues for non-calendar year plans. Before this most recent extension, the safe harbor expired Dec. 31, 2022, regardless of the plan year. For example, for an HDHP plan year starting Oct. 1, 2022, the safe harbor applied for October, November and December of 2022, but then does not apply for the remainder of that plan year. The safe harbor is again available for the plan years beginning Oct. 1, 2023, and Oct. 1, 2024.

Remember that even without this safe harbor, pre-deductible benefits for services that qualify as preventive care, including certain telehealth services, do not disqualify individuals from HSA eligibility. Note that required preventive services under the ACA must be provided without any cost-sharing. Also, IRS Notice 2020-15 allows HDHPs to cover COVID-19 testing and treatment pre-deductible. This is permitted unless and until the IRS modifies the guidance or withdraws it. For additional information on HSAs, see the prior Aflac HSA Advisory.



Consolidated Appropriations Act, 2021 (CAA 21)

The Consolidated Appropriations Act, 2021, enacted at the end of 2020, included a variety of new requirements for group health plans, most of which were first effective starting in 2022. Key provisions of CAA 21 are summarized below.

No Surprises Act (NSA) protection from "surprise medical bills"

The NSA protects group health plan participants from "surprise medical bills" from out-of-network medical care providers in three situations: (1) emergency services; 2) certain services provided by out-of-network providers at in-network facilities; and (3) air ambulance services. In connection with these protections, the NSA also imposes new requirements on group health plans.

The NSA surprise billing provisions are generally effective for plan years starting on or after Jan. 1, 2022. These provisions apply to most group health plans, including grandfathered plans, but are not applicable to excepted benefits (e.g., specified disease, hospital indemnity and other fixed indemnity excepted benefits, vision and dental coverage), account-based plans such as health reimbursement arrangements (HRAs) and health flexible spending accounts (FSAs), or stand-alone retiree health plans.

For additional information on the surprise billing provisions, see the Aflac Advisory.

Broker and consultant compensation reporting

CAA 21 requires brokers and consultants to report both direct and indirect compensation to fiduciaries of ERISA-covered group health plans, effective for contracts entered into, extended or renewed on or after Dec. 27, 2021. This reporting generally applies with respect to all group health plans, including grandfathered health plans. Unlike the surprise billing provisions, reporting also applies to retiree-only health plans and group health plans that provide excepted benefits (e.g., vision and dental benefits).

A different disclosure requirement applies with respect to agent and broker compensation for individual market plans and short-term limited duration insurance (STLDI), effective for contracts with agents and brokers executed or amended on or after Dec. 27, 2021. The disclosure must be made to current and potential policyholders. The insurer is generally responsible for disclosure, unless the agent or broker makes the required disclosures on behalf of the insurer. This requirement applies to grandfathered plans, but does not apply to excepted benefits (e.g., vision and dental plans).

Mental health and substance use disorder parity requirements — comparative analysis for nonquantitative treatment limitations (NQTLs)

CAA 21 imposed a new requirement on plans that are subject to the parity rules. The parity requirements apply to most group health plans that offer both medical/surgical benefits and mental health or substance use disorder benefits (other than retiree-only plans and excepted benefit plans). However, there is an exception for self-funded plans of small employers. For this purpose, a small employer means, in general, an employer with an average of at least two but not more than 50 employees in the prior year. The parity rules apply to fully insured plans of small employers through the essential health benefit requirements of the ACA.

The parity rules have applied to NQTL for many years; however, CAA 21 for the first time requires covered plans to perform a formal "comparative analysis" documenting how any NQTLS under the plan comply with the parity rules. Starting Feb. 10, 2021, plans are required to make the comparative analysis available to federal regulators upon request. Federal agencies are also required to issue an annual report regarding their audits relating to the comparative analysis. Plans failing to meet the requirements may be publicly mentioned in the report and required to disclose any noncompliance to plan participants. In addition, excise taxes may be imposed for noncompliance and plans may be required to pay additional amounts for benefit claims.

Transparency

The Departments of Labor, Health and Human Services and Treasury issued regulations in 2020 to implement the ACA's Transparency in Coverage rules (TiC). TiC requires most group health plans and insurers to post machine-readable files (MRFs) that disclose in-network negotiated rates, allowed amounts paid to out-of-network providers, and fee-for-service prescription drug costs at the pharmacy-location level on a public website. The MRFs must be based on a rolling 90-day period, updated monthly. Self-insured plans without public websites for posting a link to the MRFs will be in compliance if the plan's TPA (or some other third party) posts a link to the files on a public website. **The original deadline was extended to July 1, 2022 (although the deadline for posting prescription drug information has been delayed pending further guidance).**

TiC also requires plans and insurers to make individual disclosures of cost-sharing information to participants and beneficiaries (or their authorized representatives) through an internet self-service tool and/or on paper. Among other things, these individual disclosures must provide an estimate of the covered person's liability. For paper copy requests, disclosures must be provided within two business days of receiving the request, and plans may impose a limit of 20 providers per request. **For plan years beginning on or after Jan. 1, 2023, disclosures can be limited to the 500 services listed in the regulations, with information for all other services being made available for plan years beginning on or after Jan. 1, 2024.**

In a similar mandate, the NSA also requires plans to offer price comparison information both by telephone and online to allow participants and beneficiaries to compare cost-sharing for specific items or services from in-network providers. **The tri-agencies have aligned the deadlines under the ACA and NSA for these online price comparison tools to Jan. 1, 2023. Although similar, there are some substantive differences between the TiC and NSA requirements.**

The TiC and NSA requirements do not apply to excepted benefits, HRAs or other account-based plans, or stand-alone retiree plans. The TiC requirements also do not apply to grandfathered plans; however, such plans are subject to the NSA requirements. Plan sponsors can place the TiC disclosure responsibilities on the insurer or TPA by written agreement, but the liability for any failures remains with the plan sponsors of self-insured plans. Fully insured plans can shift liability for failures to the insurer through a written agreement between the plan and the insurer.

Other provisions

CAA 21 includes a number of other provisions that apply to most group health plans, such as requirements relating to health plan ID cards and provider directories, various reporting requirements, external review requirements for claims subject to the surprise billing rules, a continuity of care requirement when a provider's network status changes, and an ERISA provision prohibiting certain "gag clauses." **These provisions are generally effective for plan years starting on or after Jan. 1, 2022, but some have different effective dates. Certain requirements have been delayed until further regulations are issued, including the requirement that plans provide an Advanced Explanation of Benefits for claims subject to the surprise billing rules. Other provisions will take effect before regulations are issued. In such cases, plans are to use a reasonable, good faith interpretation of the statutory provision. An FAQ issued by the federal regulators Aug. 20, 2022, provides additional information on delays and good-faith compliance.**

Fixing the "family glitch" for ACA premium subsidies

Under the ACA, eligibility for the premium tax credit depends in part on whether the individual is eligible for employer-sponsored health coverage that is "affordable" and provides minimum value. Under initial IRS regulations issued in 2014, whether employer-sponsored coverage was considered affordable was determined based on affordability to the employee only and did not consider the cost of coverage for the employee's family members. Thus, an employee's family members could be excluded from the premium tax credit based on the cost of employer-provided coverage to the employee, even though, if the cost of family coverage were considered, it was not affordable to family members. This could occur, for example, under one common plan design where the employer pays for a larger portion of the plan cost for employees than for spouses or dependents. **Effective starting Jan. 1, 2023, new regulations fix this "family glitch" by determining affordability for family members based on the cost of the employer-sponsored coverage for the family member, not just the employee.**

The important issue for employers is that the fix of the family glitch does not impact either the ACA employer pay-or-play penalties or health coverage reporting requirements. In addition, IRS Notice 2022-41 provides that employers may offer limited midyear cafeteria plan election changes to allow family members to elect exchange coverage.

Dobbs v. Jackson Women's Health Organization

The Supreme Court's June 24, 2022, decision overruling *Roe v. Wade* has opened the way for new state law restrictions on abortion. The fact that many state abortion laws are criminal laws and the considerable differences in state laws create new areas of concern for employer plan sponsors, including sponsors of self-funded plans, as they review current coverage options for abortion services and consider possible changes. Sponsors of ERISA-covered, self-funded plans typically are not concerned with state law because of ERISA's broad preemption provision. However, state laws that restrict abortion are typically criminal laws. Generally applicable criminal laws are not preempted by ERISA, and application of preemption to civil abortion laws is not entirely clear.

In the aftermath of *Dobbs*, some employers are considering whether to adopt or modify medical travel benefits, including to cover legal abortions. Under ERISA, the easiest way to adopt a medical travel benefit is through the employer's group health plan, although other approaches may be possible. Within certain limits, medical travel benefits, including certain expenses for medically necessary travel companions, qualify as an excludable medical expense. Some employers already provide travel benefits for certain services, such as travel to medical centers of excellence. One travel benefit design that some employers have considered is to provide a travel benefit if a covered service under the plan cannot be obtained within a certain distance from where the covered individual lives. This approach is neutral with respect to the type of service to be provided, and thus may avoid potential nondiscrimination rules.

Federal law does not generally require coverage of abortion services. The Pregnancy Discrimination Act (PDA) specifically states that employers do not have to pay for health coverage for abortion services "except where the life of the mother would be endangered if the fetus were carried to term." The PDA also requires plans to cover complications arising from abortion (even if abortion is not covered by the plan), such as excessive hemorrhaging. The PDA does not preclude employers from covering abortions. Any covered benefits for abortion must be covered on the same basis as expenses for other medical conditions. The PDA generally applies to employers with 15 or more employees and is enforced by the Equal Employment Opportunity Commission (EEOC).

Due to the impact of both federal and state law, possible criminal liability under state law, as well as the differences between state laws, employers should consult their own legal counsel when reviewing current coverage or considering changes to plan coverage relating to abortion services and medical travel benefits.

Conclusion

Recent group health plan changes will continue to impact plan administration. This advisory has provided a high-level overview of key provisions. Plan sponsors and administrations should consult with their advisers as to what the provisions mean for their plans and circumstances based on the most recent guidance.

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