2023: First Quarter

Compliance Digest

Compliance Bulletins Released January to March

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2023 Compliance Bulletins: First Quarter

January

February

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2023 State Bulletins

California

Washington

State Health Coverage Reporting Requirements for Calendar Year 2022

Issued date: 01/09/23

The Internal Revenue Service ("IRS") has permanently extended the deadline to **March 2nd** each year for furnishing Affordable Care Act ("ACA") Forms 1095-C (or 1095-B) to full-time employees and other individuals to demonstrate proof of health insurance coverage for each month of the calendar year ("CY"). Form 1094-C and all Forms 1095-C for the prior CY must be furnished to the IRS by **March 31st** each year (unless eligible for paper filing, then by February 28).

For ACA compliance, the IRS permits insurance carriers to post information on their website how plan members may access and receive a copy of the Form 1095-B in lieu of automatically mailing (or electronically issuing) statements to plan members. Insurance carriers must still prepare Forms 1095-B and file these forms with the IRS no later than **March 31, 2023**, for the calendar year 2022 reporting requirements.

Currently five states (California, Massachusetts, New Jersey, Rhode Island, and Vermont) and the District of Columbia have enacted individual health insurance mandates with their own requirements for:

- furnishing information regarding health insurance coverage to residents of the state, and
- filing that information with certain state agencies.

These requirements and deadlines may (or may not) align with the federal requirements. The following chart summarizes important deadlines related to 2022 state individual mandate reporting.

State	Deadline to Furnish Statements to Employee Residents	Deadline to File Statements with State Agency
California	January 31, 2023. However, no penalty is imposed for failing to furnish by this deadline.	March 31, 2023. No penalties will be assessed if filed by May 31, 2023.
District of Columbia	March 2, 2023	April 30, 2023 (30 days after federal deadline)
Massachusetts	January 31, 2023	January 31, 2023
New Jersey	March 2, 2023	March 31, 2023
Rhode Island	March 2, 2023	March 31, 2023
Vermont	N/A	N/A

Important issues to consider regarding furnishing and issuing state-level MEC information are as follows:

- **State residents**: Employers with employees and other covered individuals residing in states with health coverage mandates should ensure the state-level health insurance distribution and state-level filing requirements are satisfied. Penalties may arise for late or incorrect filings with the state.
- **Employers with fully insured plans**: Carriers issuing policies in California, Massachusetts, New Jersey, and Rhode Island are generally obligated to issue health coverage statements to plan members residing in the respective state and to file the required health coverage information to that state agency. The District of Columbia also has reporting obligations for certain employers sponsoring fully insured plans. It should be noted that a carrier may not automatically furnish a member statement and file with a state agency for plan members residing outside of the policy issue/situs state.
- **Employers with fully insured plans issued out-of-state**: Employers should confirm that the carrier will adhere to the required state distribution and filing obligations for plan members that reside in a state with individual mandate reporting obligations.
- **Employers with self-funded plans**: Employers should confirm with their third-party administrator ("TPA") or ACA form preparation vendor that the required state distribution and filing obligations for plan members that reside in a state with an individual mandate will be satisfied and whether any additional fees will be assessed.

Employer Action

Employers with employees and/or plan members residing in a state (and/or the District of Columbia) with individual mandate reporting requirements should confirm state individual mandate reporting requirements with their carrier, TPA or ACA vendor to ensure federal as well as state-level reporting obligations will be met.

HHS Extends Public Health Emergency until April 11, 2023

Issued date: 01/13/23

On January 11, 2023, the Secretary of Health and Human Services ("HHS") renewed the COVID-19 pandemic Public Health Emergency. This will once again extend the Public Health Emergency Period (the "Emergency Period") for an additional 90 days and as a result, numerous temporary benefit plan changes will remain in effect.

Important Definitions

Emergency Period	HHS issued a Public Health Emergency beginning January 27, 2020. The Emergency Period is now set to expire **April 11, 2023** (unless further extended or shortened by HHS). HHS has indicated it will provide at least 60 days advance notice if the Emergency Period will not be extended again. We should know by February 10, 2023, if this is the last extension.
Outbreak Period	The Outbreak Period started March 1, 2020.The end date is applied on a participant-by-participant basis and is the earlier of 1) one year after the date the participant was eligible for relief, or 2) 60 days after the announced end of the COVID-19 National Emergency. As of now, the National Emergency is set to expire after February 28, 2023, unless the President announces another continuation.

The following summarizes benefit plan provisions that are directly impacted by the extension of the Emergency Period and highlights the relief with respect to the ongoing Outbreak Period. Other temporary benefit plan provisions and changes that are allowed due to the ongoing pandemic are not included.

It should be noted that some carriers and TPAs are beginning to take steps to address how a plan will treat COVID-19 benefit requirements once the Emergency Period ends. Options for plan sponsors include maintaining the status quo or removing or limiting coverage that is required while the Emergency Period is in effect.

Benefit Plan Changes in Effect Through the End of the Emergency Period

- **COVID-19 Testing.** All group health plans must cover COVID-19 tests and other services resulting in the order for a test without cost-sharing (both in-network and out-of-network), prior authorization, or medical management and includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered.
- **Over-the-Counter ("OTC") COVID-19 Testing.** Beginning January 15, 2022, all group health plans must cover OTC COVID-19 tests for diagnostic purposes without cost-sharing (both in network and out-of-network), prior authorization, medical management and without requiring medical assessment or prescription. Plans may limit the reimbursement for the purchase of OTC COVID-19 tests to eight tests per month per enrollee. Plans with established networks and direct coverage may limit the reimbursement for out-of-network OTC COVID-19 tests to up to $12 or the actual cost of the test, if less.
- **COVID-19 Vaccines.** All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers, but a plan can implement cost-sharing after the Emergency Period expires for services provided out-of-network. Note, COVID-19 vaccines are considered mandatory preventive care under the ACA and will need to be covered in-network at 100% even after the Emergency Period expires.
- **Excepted Benefits and COVID-19 Testing.** An Employee Assistance Program ("EAP") will not be considered to provide significant medical benefits solely because it offers benefits for diagnosis and testing for COVID-19 during the Emergency Period and therefore, will be able to maintain status as an excepted benefit.
- **Expanded Telehealth and Remote Care Services.** Large employers (51 or more employees) with plan years that begin before the end of the Emergency Period may offer telehealth or other remote care services to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer.
- **Summary of Benefits and Coverage ("SBC") Changes.** Group health plans may notify plan members of changes as soon as practicable and are not held to the 60-day advance notice requirement for changes affecting the SBC during the plan year or for the reversal of COVID-19 changes once the Emergency Period expires, provided the plan members are timely made aware of any increase and/or decrease in plan benefits summarized on the SBC.
- **Grandfathered plans.** If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the Emergency Period (e.g., added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status if the changes are later reversed when the Emergency Period expires.

Benefit Plan Changes in Effect Through the End of the Outbreak Period

On an individual basis, group health plans, disability, and other employee welfare benefit plans will disregard the period of one year from the date an individual is first eligible for relief, or 60 days after the announced end of the National Emergency, whichever occurs first, when determining the following:

- **COBRA.** Timeframe for the employer to provide a COBRA election notice; the 60-day election period for a qualified beneficiary to elect COBRA; the COBRA premium payment deadlines (45 days for initial payment, 30-day grace period for ongoing payments); the deadline to notify the plan of qualifying events or disability determinations.
- **HIPAA Special Enrollment.** 30 days (60 days for Medicaid/CHIP events) to request a special enrollment right due to loss of health coverage, marriage, birth, adoption, or placement for adoption.
- **ERISA Claims Deadlines.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes to request external review and perfect an incomplete request.
    - This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.
- **Fiduciary Relief of Certain Notification and Disclosure Deadlines for ERISA Plans.** A plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document throughout the duration of the Outbreak Period if the plan and fiduciary operate in good faith and furnish the notice, disclosure, or document as soon as administratively practicable (which may include the use of electronic means such as email and text messages).

It should be noted that there is retroactive application with respect to COBRA, special enrollment rights for birth of a child or adoption, and claims.

Employer Action

Employers should continue to adhere to the national pandemic-related benefit changes and expanded timeframe for providing COVID-19 testing and vaccinations and other plan requirements. State and local emergency measures may expire at different times and could impact employee benefit plans (such as insured group health plans) and other state and/or local programs (such as paid leave) differently than the timeframes required under federally regulated program requirements.

2023 Federal Poverty Guidelines Announced

Issued date: 01/24/23

The Department of Health & Human Services ("HHS") recently announced the 2023 Federal Poverty Level ("FPL") guidelines which, among other things, establish the FPL affordability safe harbor for purposes of the Affordable Care Act ("ACA") employer mandate.

For plan years beginning February 1, 2023 or later, the 2023 FPL safe harbor is $110.80/month in the lower 48 states and DC, $138.39/month for Alaska, and $127.45/month for Hawaii.

As a reminder, a plan can use poverty guidelines in effect within 6 months before the first day of the plan year for purposes of using an affordability safe harbor. Because the 2023 FPL guidelines were announced after the start of the calendar year, plans with plan years beginning on January 1, 2023 use $103.28/month for the lower 48 states and DC ($129.12/month for Alaska and $118.78/month for Hawaii), which is 9.12% of the applicable 2022 FPL. The increased threshold of $110.80/month for the lower 48 states and DC based on the 2023 FPL applies to plan years beginning on or after February 1, 2023.

Background and FPL Safe Harbor

Large employers may be subject to the employer mandate penalty under the ACA if they do not offer affordable, minimum value coverage to all full-time employees, and at least one full-time employee receives a subsidy in the Marketplace.

A large employer's offer of coverage will be considered "affordable" under the FPL safe harbor if the employee's required monthly contribution for the lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12.

2023 FPL Affordability Safe Harbor

For FPL affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The 2023 FPL is $14,580 for a single individual in every state (and Washington D.C.) except Alaska or Hawaii. Thus, if the employee's required monthly contribution for the lowest cost self-only coverage that provides minimum value is $110.80 (9.12% of $14,580/12, rounded down) or less, the employer's offer of coverage meets the FPL affordability safe harbor for a plan year beginning February 1, 2023 or later in the lower 48 states and DC.

FPL Guidelines

The following are the 2023 HHS poverty guidelines:

2023 Poverty Guidelines for the 48 Contiguous States and DC	
Persons in family/household	Poverty Guideline
1	$14,580
2	$19,720
3	$24,860
4	$30,000
5	$35,140
6	$40,280
7	$45,420
8	$50,560
For families/households with more than 8 persons, add $5,140 for each additional person.	

2023 Poverty Guidelines for Alaska	
Persons in family/household	Poverty Guideline
1	$18,210
2	$24,640
3	$31,070
4	$37,500
5	$43,930
6	$50,360
7	$56,790
8	$63,220
For families/households with more than 8 persons, add $6,430 for each additional person.	

2023 Poverty Guidelines for Hawaii	
Persons in family/household	Poverty Guideline
1	$16,770
2	$22,680
3	$28,590
4	$34,500
5	$40,410
6	$46,320
7	$52,230
8	$58,140
For families/households with more than 8 persons, add $5,910 for each additional person.	

For the new poverty guidelines, visit: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

DOL Penalties Increase for 2023

Issued date: 01/25/23

The Department of Labor ("DOL") has published the annual adjustments for 2023 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2023

The following updated penalties are applicable to health and welfare plans subject to ERISA.

Description	2022 Penalty (Old)	2023 Penalty (NEW)
Failure to file Form 5500	Up to $2,400 per day	Up to $2,586 per day
Failure of a MEWA to file reports (i.e., M-1)	Up to $1,746 per day	Up to $1,881 per day
Failure to provide CHIP Notice	Up to $127 per day per employee	Up to $137 per day per employee
Failure to disclose CHIP/Medicaid coordination to the State	$127 per day per violation (per participant/beneficiary)	$137 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,264 per failure	Up to $1,362 per failure
Failure to furnish plan documents (including SPDs/SMMs) to DOL on request	$171 per day $1,713 cap per request	$184 per day $1,846 cap per request
Genetic information failures	$127 per day (per participant/beneficiary)	$137 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$3,192 minimum	$3,439 minimum
Failure to meet genetic information requirements – not de minimis failures	$19,157 minimum	$20,641 minimum
Cap on unintentional failures to meet genetic information requirements	$638,556 maximum	$688,012 maximum

It should be noted that, with respect to certain notice and disclosure deadlines, a plan will not be in violation of ERISA for a failure to timely furnish a notice, disclosure, or document throughout the duration of the Outbreak Period if the plan and fiduciary operate in good faith and furnish the notice, disclosure, or document as soon as administratively practicable (which may include the use of electronic means such as email and text messages).

Employer Action

Private employers, including non-profits, should ensure employees receive required notices timely (SBC, CHIP, SPD, etc.) to prevent civil penalty assessments. In addition, employers should ensure Form 5500s are properly and timely filed, if applicable. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.

Emergency Periods Related to COVID-19 to End May 11, 2023

Issued date: 02/03/23

On January 30, 2023, the Biden Administration announced its intent to end the Public Health Emergency and the National Emergency related to the COVID-19 pandemic on May 11, 2023. They are currently set to expire after February 28, 2023 and on April 11, 2023, respectively.

This announcement came in response to two bills in the House of Representatives proposing to end the national emergencies at an earlier date.

As previously reported, various employee benefit plan requirements are directly impacted by the Public Health Emergency and the National Emergency. Employers sponsoring health and welfare programs will need to make some decisions with respect to their programs.

End of the Public Health Emergency

When the Public Health Emergency ("PHE") ends on May 11, 2023 various requirements as they relate to group health plan coverage, along with some helpful relief, will come to end.

- **COVID-19 Testing.** During the PHE, all group health plans must cover COVID-19 tests and other services resulting in the order for a test without cost-sharing (both in-network and out-of-network), prior authorization, or medical management and includes both traditional and non-traditional care settings in which a COVID-19 test is ordered or administered. This includes coverage for over-the counter (OTC) tests. When the PHE ends, this requirement no longer applies.

- **COVID-19 Vaccines.** All non-grandfathered group health plans must cover COVID-19 vaccines (including cost of administering) and related office visit costs without cost-sharing; this applies, to both in-network and out-of-network providers. When the PHE ends, non-grandfathered plans must continue to provide the vaccine under the ACA preventive care mandate in-network; however, cost-sharing may apply out-of-network.
- **Expanded Telehealth Relief for Large Employers.** Large employers (51 or more employees) with plan years that begin before the end of the PHE may offer telehealth or other remote care services to employees (and their dependents) who are not eligible for other group health plan coverage offered by the employer. This relief expires for plan years that begin on or after May 11, 2023 (e.g., a June 1, 2023 plan year).
- **Summary of Benefits and Coverage (SBC).** Group health plans may notify plan members of changes as soon as practicable and are not held to the 60-day advance notice requirement for changes affecting the SBC during the plan year or for the reversal of COVID-19 changes once the PHE ends, provided the plan members are timely made aware
  of any increase and/or decrease in plan benefits summarized on the SBC.
- **Grandfathered Plans.** If a grandfathered plan enhanced benefits related to COVID-19 for the duration of the PHE (e.g., added telehealth or reduced or eliminated cost-sharing), the plan will not lose grandfathered status if the changes are later reversed when the PHE ends.

Employers should review these changes and decide how to manage the expiration in May of these requirements. Carriers and third-party administrators ("TPAs") may also issue information for you to review and provide directions on next steps. In some cases (and to the extent allowed) carriers or TPAs may make changes with the next plan year.

End of the National Emergency

The Outbreak Period started March 1, 2020. It applies on an individual basis to group health plans, disability, and other employee welfare programs. Government plans (e.g., a health plan of a city or county) are not required to comply.

During this time, a plan must disregard the period of one year from the date an individual is first eligible for relief, or 60 days after the announced end of the National Emergency, whichever occurs first, when determining the following:

- **COBRA.** The timeframe for the employer to provide a COBRA election notice; the 60-day election period for a qualified beneficiary to elect COBRA; the COBRA premium payment deadlines (45 days for initial payment, 30-day grace period for ongoing payments); the deadline to notify the plan of qualifying events or disability determinations.
- **HIPAA Special Enrollment.** 30 days (60 days for Medicaid/CHIP events) to request a special enrollment right due to loss of health coverage, marriage, birth, adoption, or placement for adoption.
- **ERISA Claims Deadlines.** Timeframes to submit a claim and to appeal an adverse benefit determination. For non-grandfathered medical plans, timeframes to request external review and perfect an incomplete request.
  - This includes claim deadlines for a health FSA or HRA that occur during the Outbreak Period.

With the announced end of the National Emergency on May 11, 2023, the Outbreak Period will end **July 10, 2023**. This means original deadlines will begin to run after July 10, 2023.

It should be noted that there is retroactive application with respect to COBRA, special enrollment rights for birth of a child or adoption, and claims.

Hopefully, additional guidance as it relates to the end of the Outbreak Period and measuring deadlines is forthcoming. There are many unanswered questions as it relates to this relief.

In addition, there is fiduciary relief available during the Outbreak Period as it relates to certain notice and disclosure deadlines. Notably, many employers took advantage of good faith relief that allowed furnishing of certain notices and disclosure through electronic means, such as email or text, without having to satisfy more burdensome electronic delivery requirements. This relief will also expire after July 10, 2023.

Other Relief

There is other relief for qualified high deductible health plans ("HDHPs") with a health savings account ("HSA") that came about as a result of the COVID-19 pandemic but is not tied to the PHE or National Emergency. As such, these provisions should not be affected when these timeframes end.

- **IRS Notice 2020-15.** Allows a qualified HDHP to provide coverage for COVID-19 testing or treatment before the IRS deductible is satisfied without jeopardizing HSA eligibility. This relief applies until further guidance is issued. It does not appear that the end of the PHE will affect this relief, unless the IRS issues guidance stating otherwise.
- **Telehealth Relief.** For plan years that begin after December 31, 2022 and before January 1, 2025, an HDHP/HSA plan may offer telehealth or other remote care services before the minimum IRS deductible is satisfied without jeopardizing HSA eligibility.

Special Enrollment Opportunity

As a result of the end of the PHE, it is expected that many individuals will lose eligibility for Medicaid and the Children's Health Insurance Program ("CHIP"). The loss of Medicaid or CHIP coverage is a special enrollment opportunity onto a group health plan sponsored by an employer. Employers should be prepared to address requests for special enrollment from otherwise eligible employees who lose Medicaid or CHIP coverage.

Employer Action

With respect to the end of the PHE, employers should discuss benefit plan design changes with carriers and TPAs. Employers should be prepared to address requests for special enrollment as a result of a loss of eligibility for Medicaid or CHIP.

Employers should also monitor developments as the government funding to purchase COVID-19 vaccines is expected to end. Most group health plans will need to cover the cost of the vaccine as required preventive care (along with the administration) in-network and without cost-sharing. Reports from Pfizer and Moderna indicate the commercial cost could range between $110-130 per dose.

With respect to the end of the Outbreak Period, employers should:

- Await additional guidance from the regulators; and
- Consider providing notice to employees that the extended deadlines will come to an end on July 10, 2023 and discuss COBRA implications with COBRA vendors.

Notification Reminder for Forms 1095-C and 1095-B

Issued date: 02/07/23

Under the Affordable Care Act ("ACA"), the deadline for applicable large employers ("ALEs") to furnish Form 1095-C and 1095-B to certain individuals (such as full-time employees in the case of Form 1095-C) is January 31 with respect to the preceding calendar year. The Internal Revenue Service ("IRS") released final regulations on December 12, 2022 with respect to ACA reporting requirements. These final regulations provided an automatic extension of 30 days to furnish these statements to individuals.

This means that Wednesday, March 2, 2023 is the deadline to furnish individuals with 2022 Forms 1095-C and 1095-B. This extension is automatic; employers or other reporting entities are not required to file a request with the IRS, or to demonstrate reasonable cause to justify the extension.

It should be noted that the final rule did not extend the deadline to file completed Forms 1095-C and 1095-B with the IRS. This due date remains March 31, 2023 (or February 28, 2023 for paper filing if filing fewer than 250 forms).

While the IRS has provided the automatic extension of time to furnish these statements, it should be noted that if an ALE is operating in a state with an individual mandate, the timing to furnish proof of coverage to covered residents may be different.

Alternative Method for Furnishing ACA Statements

Under the ACA, IRS Forms 1095-C and 1095-B must be sent by first class mail to the last known permanent address of the individual. If no permanent address is known, the statement must be sent by first class mail to the individual's temporary address. The statement may also be furnished electronically if certain requirements are met.

The final regulations make permanent an alternative method for furnishing IRS Form 1095-B to individuals, for as long as penalties under the ACA's individual shared responsibility rules remain zero. The alternative method is available to the following reporting entities:

- Health insurance carriers and plan sponsors (other than ALEs) that are using IRS Form 1095-B to provide proof of MEC
- ALEs with a self-funded group medical plan that are using IRS Form 1095-B to provide proof of MEC to individuals who are not considered "full-time" under the ACA for any month of the calendar year (i.e., non-full-time employees and non-employees covered under the plan during the calendar year)
- Small employers (not ALEs) with a self-funded health plan that are using IRS Form 1095-B to provide proof of MEC

It should be noted that the alternative method is not available to ALEs that are furnishing IRS Form 1095-C to employees considered "full-time" under the ACA for one or more months of the calendar year. Further, the alternative method may not be available if operating in a state with an individual mandate where Forms 1095-C or 1095-B must be furnished to covered residents. Keep in mind, if the alternative method is used, the reporting entity must still file the Form 1095-B with the IRS.

The following steps must be followed by a reporting entity that elects to use the alternative method:

- A clear and conspicuous notice that meets certain technical requirements must appear on the reporting entity's website
- The notice must state that covered individuals may receive a copy of IRS Form 1095-B upon request, and informs them how the request may be made
- The notice must appear in the same website location through October 15 (or the next business day if October 15 falls on a Saturday, Sunday, or legal holiday) following the end of the calendar year to which the form relates
- IRS Form 1095-B must be furnished to the requesting individual within 30 days after the request is received; the ACA statement may be furnished electronically if certain requirements are met.

Employer Action

With respect to furnishing Forms 1095-C and 1095-B for CY 2022, employers must furnish these statements to individuals no later than March 2, 2023. Final Forms and Instructions are now available.

Employers should know whether carriers will take advantage of the alternative furnishing method with respect to Forms 1095-B they issue.

Employers in a state with an individual mandate (California, District of Columbia, Massachusetts, New Jersey, Rhode Island, and Vermont), and required to furnish covered residents with proof of coverage during the calendar year, should continue to comply with state rules.

Air Ambulance Reporting Update

Issued date: 02/13/23

As previously reported, group health plans will be required to submit information related to air ambulance claims to the Department of Health and Human Services (“HHS”).

In a September 2021 proposed rule, the regulators expected that rulemaking would be finalized during 2021, and that plans and carriers would be required to submit the data for calendar year 2022 by March 31, 2023, and the data for calendar year 2023 by March 31, 2024.

However, under the statute, the reporting is not due until regulations are final, and the proposed rule has not been finalized. As a result, absent further guidance, there should be no reporting requirement in 2023. HHS has unofficially stated there would be no data collection in 2023.

Once regulations are finalized, the reporting requirements will become effective. We anticipate that the final rule will include due dates for reporting. We will continue to monitor the guidance and provide updated information when available.

Employer Action

Group health plans will not need to submit the air ambulance report in 2023.

Keep an eye out for additional guidance, including issuance of a final rule.

Once guidance is finalized, coordinate with carriers and third-party administrators to ensure reporting is prepared and timely submitted.

Medicare Part D – CMS Notification Reminder

Issued date: 02/24/23

Employers sponsoring a group health plan (whether insured or self-insured) need to report information on the creditable (or non-creditable) status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). In order to provide this information, employers must access CMS's online reporting system at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html.

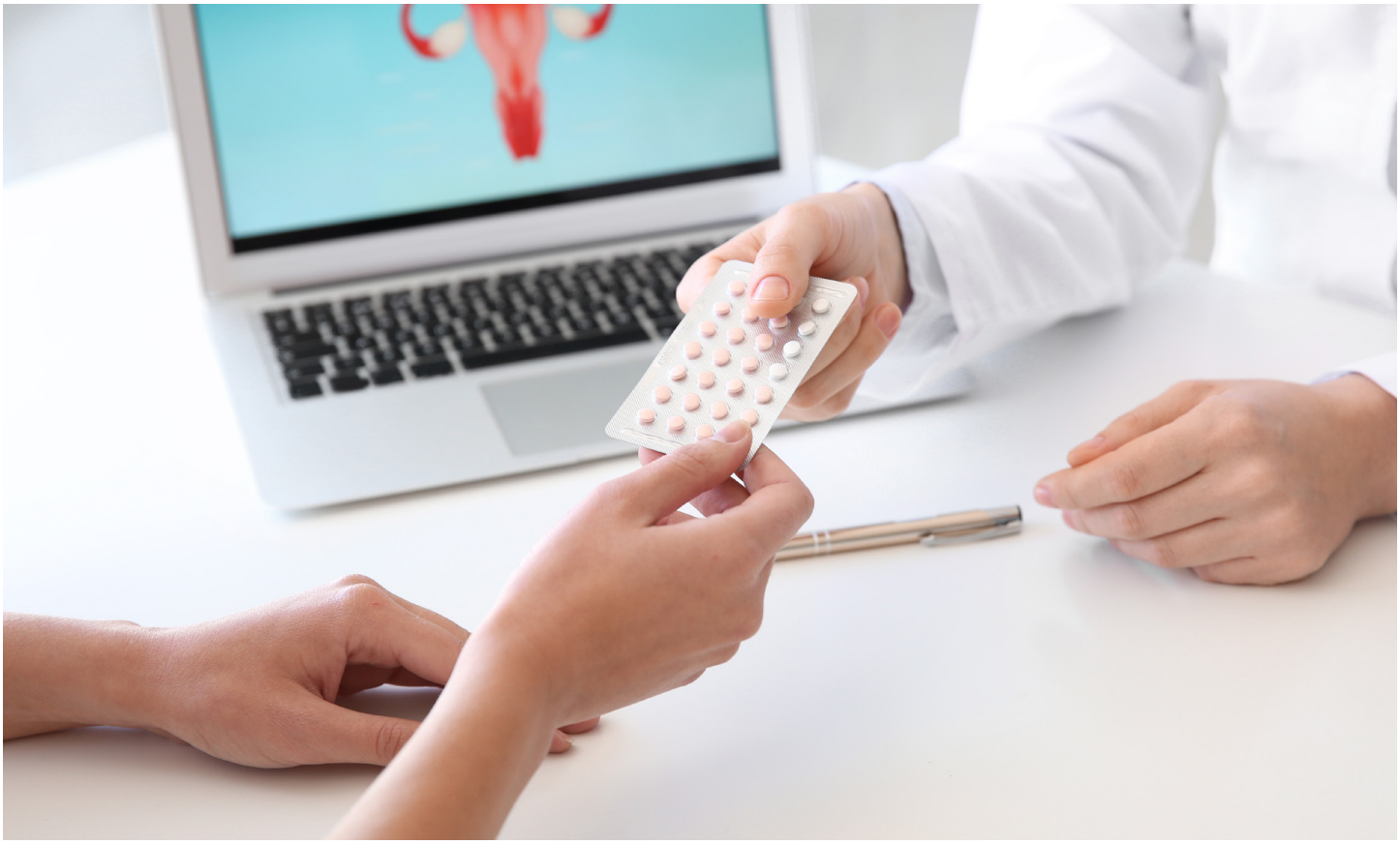
As a reminder, notice must be provided by the following deadlines:

- Within 60 days after the beginning date of each plan year;
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status of the prescription drug plan.

For example, an employer with a calendar year plan (January 1 – December 31, 2023) must complete this reporting **no later than Wednesday, March 1, 2023**.

Additional resources on completing the form is available at:

- https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html



Proposed Update to Contraceptive Services Mandate

Issued date: 02/24/23

On January 30, 2023, the Departments of Labor, Treasury, and Health and Human Services (collectively, "the Departments") issued a new proposed regulation related to the provision of contraceptive services in a group health plan. This rule would strengthen access to birth control coverage under the Affordable Care Act ("ACA") so that all women who need or want birth control are able to obtain it. Briefly, the rule:

- Creates a new, optional pathway for individuals to obtain contraceptive services when a group health plan does not provide such services due to religious objection; and
- Removes the existing exemption for moral objection.

Background

Under the ACA's preventive care mandate, all non-grandfathered group health plans must cover all FDA-approved contraceptive services without participant cost-sharing.

Under a final rule issued in 2018, non-governmental employers sponsoring a group health plan and objecting to providing some (or all) of the mandated contraceptive services based on seriously held religious beliefs or moral objection are exempt from the requirement. An optional accommodations process is available to allow participants to obtain contraceptives for no cost from a carrier and/or TPA without involvement of the objecting employer sponsor.

What's New?

The new proposed rule creates individual contraceptive arrangements for participants to obtain contraceptives without the involvement of their objecting plan sponsor that invoked the religious exemption and does not use the optional accommodation process.

Under the proposed rule, a willing provider may provide contraceptive services directly to eligible individuals at no cost. The provider will then seek reimbursement from a health insurance carrier participating in the federal or state-run Exchange and that carrier will, in turn, receive a reduction in Exchange user fees. Objecting group health plan sponsors are not required to provide notice to participants of the availability of this process, although they are still subject to the disclosure rules that normally apply to group health plans such as SPD and SBC distribution.

Additionally, the proposed rule would rescind the moral objection exemption from the contraceptive mandate. Group health plans that previously relied on this exemption would be required to cover contraceptive services. The proposed rule does not make any changes to the exemption or accommodation process for religious objection.

Employer Action

Group health plans excluding coverage of contraceptives under a religious exemption may continue to do so without further action. Plans that exclude coverage of contraceptives under non-religious moral grounds may need to consider changes to contraceptive coverage if the rule is finalized "as is." The Departments are seeking comment on the type and magnitude this design change would have on plans who historically have relied on the moral objection exemption, as well as alternatives to
a full rescission.

It should be noted that this rule is in proposed form and is not final. Any final rule may change from the proposed rule and should include an effective date. It is possible, when finalized, that the new rule could face legal challenges.

California Requires COVID-19 Coverage After Emergency Ends

Issued date: 02/28/23

California has enacted a state insurance law that generally requires group health insurance policies and health maintenance organizations (“HMOs”) in California to continue covering the cost of COVID-19 testing, vaccinations, and therapeutics after the end of the federal Public Health Emergency (“PHE”) related to the COVID-19 pandemic. The Biden administration has announced its intention to end the federal PHE on May 11, 2023.

COVID-19 Testing and Vaccination Coverage

After the end of the federal PHE, this California insurance law will apply as follows:

Group health insurance policies and HMOs in California are generally required to continue to cover the cost of COVID-19 diagnostic and screening testing and the cost of COVID-19 vaccinations, without cost-sharing and without prior authorization or other utilization management requirements, whether delivered by an in-network provider or an out-of-network provider. These requirements are the same as those in place during the federal PHE.

However, beginning six months after the federal PHE ends (November 11, 2023, if the federal PHE ends as expected on May 11, 2023), group health insurance policies and HMOs in California may impose cost-sharing when the COVID-19 testing or vaccinations are delivered by an out-of-network provider (unless otherwise required by law).

COVID-19 Therapeutics Coverage

California insurance law also requires group health insurance policies and HMOs to cover the cost of COVID-19 therapeutics (treatments intended to be administered as soon as possible after an individual's positive COVID-19 test result), without cost-sharing and without prior authorization or other utilization management requirements, whether delivered by an in-network provider or an out-of-network provider.

These requirements generally apply to group health insurance policies and HMO contracts that are issued, amended, or renewed after September 25, 2022, and continue to apply after the end of the federal PHE.

However, beginning six months after the federal PHE ends (November 11, 2023, if the federal PHE ends as expected on May 11, 2023), group health insurance policies and HMOs may impose cost-sharing when COVID therapeutics are delivered by an out-of-network provider (unless otherwise required by law).

Application of California Insurance Law to Group Health Plans

The California insurance law requirements set forth above generally apply to:

- Group health insurance policies issued or delivered (i.e., sitused) in California
- HMOs in California
- Group health insurance policies issued or delivered (i.e., sitused) outside of California, to the extent that the policy covers California residents; but not if (a) the employer's principal place of business is located outside of California, and (b) a majority of employees are located outside of California

The California law does not apply to specialized health insurance policies that provide only dental or vision-care benefits, and to certain other insurance policies. In addition, the California law does not apply to any self-funded group health plan.

Employer Action

Employers that maintain a fully insured group health plan sitused in California should be aware of the requirements of this California insurance law.

Employers that maintain a fully insured group health plan sitused outside of California that covers California residents should keep records relating to the location of its principal place of business and the location of its employees, for purposes of determining the extraterritorial application of California insurance law to its plan.

FAQs Address Gag Clause Prohibition and Attestation

Issued date: 03/08/23

The Departments of Labor, Health and Human Services ("HHS"), and the Treasury (collectively, "the Departments") issued FAQ 57, providing the first guidance as it relates to the prohibition on gag clauses in provider agreements and the annual attestation as required under the Consolidated Appropriation Act of 2021 ("CAA-21").

Among other things, the guidance requires group health plans and health insurance carriers to submit an annual attestation with the first attestation due no later than December 31, 2023.

Below you will find additional clarification provided by the FAQs:

What is a "gag clause?"

A "gag clause" is a contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party. These clauses may be found in agreements between a plan or carrier and any of the following parties:

- a health care provider;
- a network or association of providers;
- a third-party administrator ("TPA"); or
- another service provider offering access to a network of providers.

Under the CAA-21, group health plans and carriers offering group health insurance are prohibited from entering into agreements with providers, TPAs or other service providers that include language that would constitute a "gag clause" and restrict:

1. Disclosure of provider specific cost or quality of care information to referring providers, the plan sponsor, participants, beneficiaries and or any other plan members;
2. Electronic access to de-identified claims and encounter information or data for each participant, beneficiary or enrollee in the plan upon request and consistent with relevant privacy rules; and
3. Sharing information or data described above or directing that such information or data be shared with a business associate.

Plans and carriers must annually submit to the Departments an attestation that the plan or carrier complies with these requirements ("Attestation").

The Attestation

The first Attestation is due no later than December 31, 2023, covering the period from December 27, 2020 through the date of the Attestation. Subsequent Attestations will be due by December 31 of each year and cover the period since the last Attestation was submitted.

The Attestation must be submitted to the Centers of Medicare and Medicaid Services ("CMS") through a webform. An authentication code to access to the web form is required and generated upon request. CMS issued a detailed instructions document with relevant submission information, which can be found at https://www.cms.gov/files/document/gag-clause-prohibition-compliance-attestation-instructions.pdf.

A reporting entity, generally the group health plan or group health insurance carrier, is responsible for ensuring either that it annually attests or has another party (e.g., carrier, TPA) attest on its behalf that the reporting entity is in compliance with the prohibition on gag clauses.

Fully insured plans

If a group health plan is fully insured, both the carrier and the plan are subject to the Attestation. However, the Departments will consider both the carrier and the plan to have met the attestation requirement if the carrier submits Attestations on behalf of the plan. Employers with fully insured plans should confirm the carrier will handle this obligation.

Self-funded (including level funded plans)

A self-funded plan is responsible for compliance and may satisfy the requirement by entering into a written agreement under which the plan's service provider (e.g., TPA) attests on its behalf. But like other CAA provisions, the legal responsibility will remain with the plan. Employers should seek written assurances from TPAs and other services providers that they will submit the attestation on their behalf.

The following plans are not subject to the requirement, and therefore do not need to attest:

- Account based plans such as a health FSA, HRA and ICHRA
- Excepted benefits, such as hospital indemnity insurance, dental and vision
- Short-term limited duration insurance

Employer Action

Employers should ensure that their group health plans do not include language or other restrictions that are considered "gag clauses" and coordinate with relevant carriers, TPAs and other service providers to timely submit the Attestation. The first due date is December 31, 2023. It should be noted that, although the first Attestation is not due until December 31, 2023, some employers have already received letters from HHS indicating that CMS is now collecting Attestations.

Employers with fully insured plans should confirm carriers will submit the Attestation on behalf of the insured group health plan. No further action is required if the carrier handles this step.

Employers with self-funded plans should enter into an agreement to have their TPA, PBM or other third party submit the Attestations on its behalf.

2022 RxDC Reporting Instructions Released

Issued date: 03/31/23

The Centers for Medicare and Medicaid Services ("CMS") recently released updated RxDC reporting instructions, the HIOS Manual User Guide, and the HIOS Quick Guide related to reporting 2022 data. While substantially rearranged, the substance of the instructions largely remains the same. Nevertheless, there are some notable changes.

Background

As previously reported, plan sponsors of group health plans must submit information annually about prescription drugs and health care spending ("RxDC reporting") to CMS. The first deadline was December 27, 2022 (extended to January 31, 2023) for reporting on calendar years 2020 and 2021. The next deadline is June 1, 2023, for reporting on calendar year 2022.

It should be noted that carriers, pharmacy benefit managers ("PBMs"), and third-party administrators ("TPAs") assisting with the reporting may have earlier deadlines for employers to respond to them with certain data points (e.g., plan name, average monthly premiums).

New Instructions

The following are the most relevant changes from the prior year:

- The enforcement relief available for failure to report average monthly premium paid by employers and members for 2020/2021 reporting is not available for 2022 reporting. Additionally, no other good faith relief has been extended with respect to 2022 reporting at this time.

- Changes providing clarification about what should be reported in D1 and D2 files:
  - Prescription drug rebates should be subtracted from premium equivalents in D1 regardless of whether the rebate received in the reference year is retrospective or prospective.Stop-loss reimbursements should be subtracted from premium equivalents in D1.
  - Stop-loss reimbursements should not be subtracted from total spending in D2.
  - Prescription drug rebates expected, but not yet received, should be subtracted from total spending in D2.
- Changes to incorporate lessons learned from the first submission date, particularly around making the submission more efficient and more precise.
  - There is an additional option for multiple vendors to submit the same data file on behalf of the same plan, issuer, or carrier.
    - Plans and carriers and their reporting entities are encouraged to work together to submit only one data file of each data file type for the same plan, issuer, or carrier. For example, if one reporting entity is responsible for only some of the fields in a data file, it might fill out those fields and then give the data file to the other reporting entity to complete the remaining information before submitting the data file in HIOS.
    - However, if entities are unwilling or unable to work together, more than one reporting entity may submit the same type of data file on behalf of the same plan, issuer, or carrier. For example, if a plan has two issuers, one for behavioral health benefits and another for other medical benefits, then both issuers can submit D2 on behalf of the plan. The first issuer's D2 would include the plan's data related to behavioral health benefits. The second issuer's D2 would include the plan's data related to other medical benefits.
    - Similarly, if a plan or carrier changes vendors during the reference year (such as changing a TPA or PBM), it's acceptable for the previous vendor to report the data from the period prior to the change, and the new vendor to report the data from the period beginning on the date the change was effective. Alternatively, the previous vendor may provide the data to the new vendor and the new vendor would report the entire year of data.
- There is an additional option for a reporting entity to create multiple submissions in HIOS for the same reference year.
  - A reporting entity may make multiple submissions in HIOS if the content of the submissions is mutually exclusive. That is, if a reporting entity creates multiple submissions, each plan in the plan lists and data files must be included in only one of the submissions. If multiple submissions with overlapping content are accidentally created, the RxDC HIOS Manual User Guide contains instructions on editing and deleting submissions. CMS discourages reporting entities from making multiple submissions in HIOS.
- Changes related to when reporting is and is not required:
  - RxDC reporting requirements do not apply to retiree-only plans.
  - Reporting must be done for all 50 states, the District of Columbia, and the U.S. territories.
  - Plans and carriers should make their own determination on whether to include information about prescriptions filled in other countries.

- Examples of when wellness services are billed on a claim and thus reportable:
    - A member sees a provider for the placement of a nicotine patch to help with smoking cessation, and the provider submits a claim for providing this service (for example, using codes CPT 1036f and S4990). This is a billed claim.
    - A member receives a gift card for completing a smoking cessation program. This is not a billed claim.

HIOS Guidance

The HIOS Manual User Guide and HIOS Quick Guide have been substantially changed, increasing from 8 pages to 34 pages. The first 3 pages include specific information that registrants should omit.

At this time, it does not appear the email reporting option available for 2020/2021 reporting will be available for employers responsible for filing P2 and D1 themselves for 2022. Therefore, if an employer needs to submit one (or more) of the "D" files (e.g., D1) on behalf of the group health plan because a TPA or PBM is not handling the full filing, the employer should sign up for a HIOS account.

Employer Action

With respect to these new instructions, employers should:

- Identify which of the above changes will impact their filing this year.
- Work with carrier partners, TPAs, PBMs and other vendors, as appropriate, to submit the requisite 2022 data.

The instructions themselves are helpful and answer questions about the filing requirement and provide relevant examples when appropriate.

Additional guidance and/or relief could be issued before the June 1, 2023 filing deadline. We will continue to monitor and inform you of any applicable changes.

San Francisco Supplemental Pay for Military Leave

San Francisco now requires certain employers to provide up to 30 days of supplemental pay to employees who are on leave for military duty.

Background

On January 20, 2023, the mayor of San Francisco approved an Ordinance passed by the Board of Supervisors called the "Private Sector Military Leave Pay Protection Act." This Ordinance is intended to minimize the financial hardship of an employee who is absent from work due to military duty by mandating the employer provide partial pay to the employee for up to 30 days.

This Ordinance is administered and enforced by the San Francisco Office of Labor Standards Enforcement ("OLSE"). On February 16, 2023, the OLSE published implementation guidance on this Ordinance in the form of Frequently Asked Questions.

The requirements of the Ordinance became effective on February 19, 2023.

Covered Employers

The Ordinance applies to every employer with at least 100 employees worldwide, regardless of company location or headquarters. However, the Ordinance does not apply to any governmental employer (including the City and County of San Francisco) or to private businesses located in the Presidio, Fort Mason, the Golden Gate National Recreation Area, or other federal enclave.

All employees performing work for the employer worldwide are counted toward the threshold. If the number of employees fluctuates above and below 100 over the course of a year, the employer's size is calculated based on the average number of employees per pay period during the prior calendar year.

Covered Employees

The Ordinance applies to any employee (including any part-time or temporary employee) who both:

- performs work within the geographic boundaries of San Francisco for a covered employer, and
- is a member of the reserve corps of the US Armed Forces, National Guard, or other US uniformed service organization.

Covered Military Duty

The Ordinance applies to a covered employee's leave for military duty, for up to 30 days in a calendar year. "Military duty" is defined as:

- active military service in response to the September 11, 2001 terrorist attacks, international terrorism, the conflict in Iraq, or related extraordinary circumstances, or military service to provide medical or logistical support to federal, state, or local government responses to the COVID-19 pandemic, natural disasters, or engagement in military duty ordered for the purposes of military training, drills, encampment, naval cruises, special exercises, Emergency State Active Duty, or like activity.

Examples of military duty are when the covered employee is deployed to respond to a natural disaster or military conflict, or attends required annual military training.

Supplemental Pay Calculation

For the period during which covered employees are on leave for military duty, the covered employer must pay them (for up to 30 days in a calendar year) the difference between their gross military pay and the amount of gross pay they would have received from the employer had they worked their regular work schedule (for the hours that would have been worked in San Francisco) instead of being absent for military leave.

Gross military pay is the basic pay rate the employee receives for military service, excluding military pay allowances such as those for combat, clothing, housing, or aviation. The employer can estimate the amount of gross military pay by asking employees to provide a copy of their military orders (which disclose their military rank), and then looking up the federal Armed Forces basic pay rate for their military rank at www.dfas.mil (if the military orders do not already state their gross military pay). Also, after the leave ends, the employer can ask the employees to provide a wage statement verifying the military gross pay they actually received during the relevant period of military leave, and adjust for any discrepancies on the next paycheck.

Gross pay from the employer is easily calculated if covered employees have a regular work schedule (e.g., 40 hours per week every week), or have a work schedule predetermined for the time when they are required to take military leave. Otherwise, their "regular work schedule" can be determined by looking at the three monthly pay periods, six bi-weekly or semi-monthly pay periods, or twelve weekly pay periods immediately preceding the relevant period of military leave. Gross pay includes overtime pay if the employee's regular work schedule includes overtime. The calculation of gross pay should not include any pay periods during which the employee was on unpaid or partially paid leave prior to the relevant period of military leave.

The employer is required to make a good faith effort to provide the supplemental pay no later than the payday for the payroll period when the employee's military leave begins. Covered employees receiving supplemental pay while on leave for military duty should not receive more total compensation than they would have received by working their regular work schedule.

For those employees who receive supplemental pay under the Ordinance but who fail to return to their position with the employer within 60 days after being released from military duty (despite being fit for employment), the employer is permitted to treat the supplemental pay as a loan at a specified interest rate that must be paid back to the employer in equal monthly installments over a period not to exceed five years.

Employer Action

- Covered employers may require covered employees to comply with reasonable notice procedures, such as providing the employer with advance notice of the employee's use of supplemental pay for military leave, but only when the need for military leave is foreseeable (such as for scheduled trainings).
- Within a reasonable time after covered employees tell their covered employer they received written military orders and will require time off work, the employer should provide them with a notice of their right to supplemental pay under the Ordinance.
- If a covered employer publishes an employee handbook that describes other kinds of leave available to its employees, the employer must include a description of the right to supplemental pay under the Ordinance in the next edition of the handbook that is published.
- A covered employer should stay up-to-date on displaying the current labor law posters required at each San Francisco workplace or jobsite. The OLSE has indicated it will include a notification of the employee right to supplemental pay under the Ordinance in the labor law posters it updates annually and provides for employers.
- Covered employers must retain records for at least four years relating to employee schedules and hours worked, and military leave taken by covered employees, for purposes of documenting their compliance with the supplemental pay requirements of the Ordinance.

Reminder: San Francisco HCSO Reporting Due May 1

As a reminder, employers covered under the San Francisco Health Care Security Ordinance ("HCSO") need to submit the 2022 Employer Annual Reporting Form by **Monday, May 1, 2023**. The form is completed and submitted online at https://sf.gov/submit-employer-annual-reporting-form-olse-0.

This annual reporting includes the reporting requirement associated with San Francisco's Fair Chance Ordinance ("FCO"). Details related to the FCO are not addressed in this summary; visit the FCO website of the San Francisco Office of Labor Standards Enforcement ("OLSE") for more information.

Employer Annual Reporting Form

Under the HCSO, covered employers must make minimum health care expenditures for each hour worked by covered employees in San Francisco.

Covered employers must also submit an online Employer Annual Reporting Form each year that summarizes how they complied with the HCSO.

The Form is normally due on April 30th of the following year, but since that date falls on a Sunday this year, the deadline to submit the 2022 Form has been shifted to Monday, May 1, 2023. The penalty for failing to timely submit the Employer Annual Reporting Form is up to $500 per quarter.

An employer that was not covered by the HCSO and/or the FCO in any quarter of calendar year 2022 does not need to submit the Form. To determine whether the Form is required, an employer will answer the short survey on the first page of the online Form. Employers that were not covered by the HCSO or the FCO in 2022 will be directed to a webpage indicating that they do not need to submit the Form, and no further action is required. Covered employers will be directed to the appropriate online Form.

The OLSE has made a pdf of the 2022 Form available for employers who wish to preview the Form before completing it online (https://sf.gov/sites/default/files/2023-02/2022%20ARF%20PDF%20Preview_website.pdf). It has also published instructions for completing the 2022 Form (https://sf.gov/reports/february-2023/2022-arf-instructions).

HCSO Notice to Employees

If they haven't already, covered employers should make sure to post the official 2023 HCSO Notice in a conspicuous place at any employer workplace or job site where covered employees work. The Notice should also be mailed or emailed to employees who do not work at an employer workplace or job site, such as employees working from home. The Notice is available in several languages at https://sf.gov/sites/default/files/2022-12/2023%20HCSO%20poster.pdf.

Washington LTC Voluntary Exemptions Categories Added

As previously reported, Washington's Long-Term Services and Supports Trust Program (now referred to as "WA Cares Fund") was delayed to allow the legislature to make changes to the program including adding individual exemption categories.

Beginning January 1, 2023, eligible individuals may apply for new exemptions based on newly added criteria described below.

Also, as a reminder, premium withholding for the program begins July 1, 2023.

Background

Beginning July 1, 2023, a 0.58% premium assessment applies on wages of all Washington employees to fund the WA Cares Fund. The program will provide long-term care benefits to eligible Washington residents (up to $36,500). All wages are subject to the premium assessment; there is no cap.

During the 2022 legislative session, ESHB 1733 was passed establishing four new categories of employees who may be eligible for a voluntary exemption from the payment of premiums to (and benefits from) the WA Cares Fund.

Briefly, the new exemptions are for people who are:

- **Disabled veterans**. An employee who is a veteran of the United States military who has been rated by the United States Department of Veterans Affairs as having a service-connected disability of at least 70 percent. This is the only permanent exemption created by ESHB 1733.
- **Spouse or registered domestic partners of an active duty service member**. An employee who is the spouse or registered domestic partner of an active duty service member of the United States Armed Forces. This exemption is temporary and must be discontinued within 90 days of either the employee's spouse or registered domestic partner being discharged or separated from military service, or the dissolution of the employee's marriage or registered domestic partnership.
- **Temporary employees with a nonimmigrant visa**. An employee who holds a nonimmigrant visa for temporary workers who is employed by an employer in Washington may apply for an exemption. This exemption is temporary and must be discontinued within 90 days of an employee's nonimmigrant visa for temporary workers status being terminated and the employee becoming a permanent resident or citizen employed in Washington
- **Living outside of Washington**. An employee who is employed in Washington but maintains a permanent residence outside of Washington as the employee's primary location of residence may apply for an exemption. The exemption is temporary and must be terminated within 90 days of the employee establishing a permanent address within Washington as the employee's primary location of residence.

Exemption Process

Washington's Employer Security Department ("ESD") recently opened the application process for eligible individuals who would like to apply for one of these exemptions.

The new exemptions are available on an ongoing basis. Individuals need to create a SecureAccessWashingon (SAW) account to apply. Information about establishing SAW accounts is available online at: https://wacaresfund.wa.gov/apply-for-an-exemption/

Individual exemptions are effective the quarter after the exemption is approved. Individuals with approved exemptions will receive an exemption approval letter from ESD which will need to be presented to current and future employers to avoid premium deductions. Failure to present the exemption approval letter to an employer could result in premium deductions that will not be returned to the employee.

It should be noted that employers cannot apply for exemptions on behalf of employees. The employee must apply for their own exemption.

What about exemptions for a private long-term care policy?

Individuals with private long-term care insurance before Nov. 1, 2021, were able to apply for a permanent exemption from the WA Cares Fund from Oct. 1, 2021, until Dec. 31, 2022. Individuals needed to secure the exemption within this timeframe. It is no longer available.

Employer Action

Employees who qualify for and would like to claim an exemption must apply on the WA Cares Fund website. Employees have the responsibility to notify and provide employers with a copy of any approved exemption letter for ESD. Once provided with that letter (and the effective date has passed), employers should not withhold premiums for WA Cares Fund. Any incorrectly withheld premiums should be returned to the employee.

Employers should coordinate with payroll to prepare for premium collection beginning July 1, 2023.