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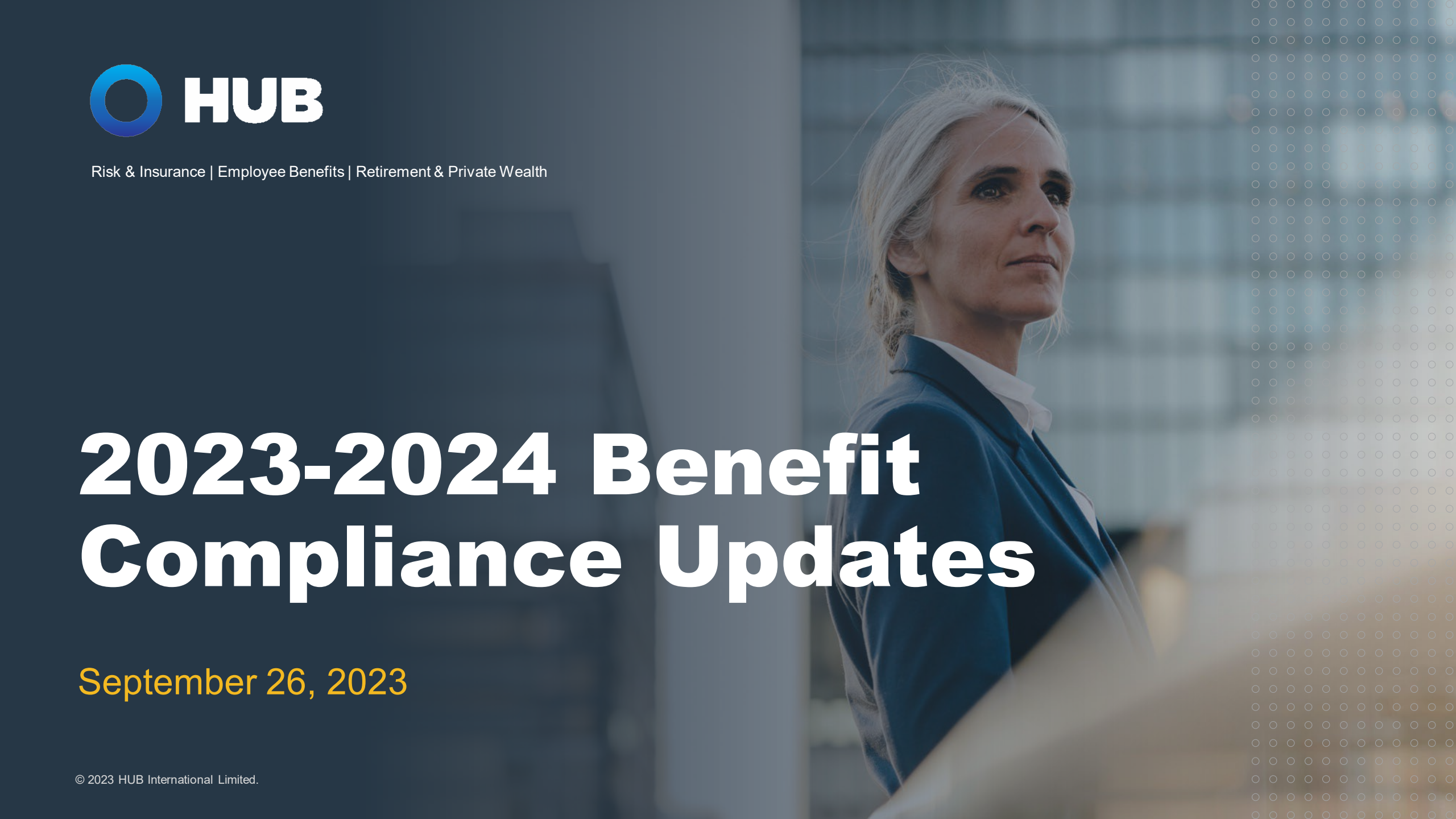
Risk & Insurance | Employee Benefits | Retirement & Private Wealth



2023-2024 Benefit Compliance Updates

September 26, 2023

Liliana Salazar, Esq.

Chief Compliance Officer
Pacific Region Employee Benefits

Liliana.Salazar@hubinternational.com
HUB International

Agenda

1. COVID Updates
2. Transparency and Reporting
3. ACA Reminders and Updates
4. Other Updates and Reminders
5. Q&A

End of the Outbreak Period- July 10,2023

End of Outbreak period **July 10,2023**

COBRA

Timing	Regulations	COVID-19- NO ER IN EFFECT
Election	60 days	60 days following the end of the Outbreak Period
Initial Payment	45 days	45 days following the end of the Outbreak Period
Subsequent Payments	30 days	30 days following the end of the Outbreak Period
Notify Plans of Qualifying Events	30 – 60 days generally depending on event	30 – 60 days following the end of the Outbreak Period

HIPAA Special Enrollment Rights

Event	Regulations	COVID -19 NO ER IN EFFECT
Loss of Other Coverage	30 days	30 days following the end of the Outbreak Period
Acquisition of a New Dependent	30 days	30 days following the end of the Outbreak Period
Eligibility for State Assistance	60 days	60 days following the end of the Outbreak Period

End of the Outbreak Period- July 10,2023

End of Outbreak period **July 10,2023**

ERISA Claims Procedures

Timing	Regulations	COVID-19 [illegible] NGER IN EFFECT
Initial Claim filing	12 months or as allowed by the plan	Outbreak period is not included in determining if the claim was filed on a timely basis
Appeal a Denied Claim	180 days of denial	Outbreak period is not included in determining if the claim was filed on a timely basis
External Review Determination	Four months after the notice of denial	Outbreak period is not included in determining if the claim was filed on a timely basis
Submit additional information to appeal a claim (external review)	Within the four months of the denial or 48-hours of notice being granted	Outbreak period is not included in determining if the claim was filed on a timely basis

IRS Notice 2023-37 – COVID-19 Testing and Treatment

On June 23, 2023, the IRS published Notice 2023-37, "Expenses Related to COVID-19 and Preventive Care for Purposes of High Deductible Health Plans."

Background: During the COVID-19 Public Health Emergency, IRS Notice 2020-15 permitted HDHPs to provide COVID-19 testing and treatment services and items before satisfying the deductible, without affecting employees' HSA eligibility.

- HDHPs may continue to provide benefits related to testing or treatment for COVID-19 before satisfying the minimum deductible under an HDHP, but **only through plan years ending on or before December 31, 2024.**
- Provides a safe harbor for the absence of a deductible for preventive care benefits. A HDHP can provide preventive care benefits before satisfying the deductible or with a lower deductible than the required minimum annual deductible.
- Preventive care safe harbor under 2004-23 does not include COVID-19 testing, but plans can continue to provide COVID-19 testing benefits as first dollar coverage through plan years ending on **or before December 31, 2024**.

2

Transparency & No Surprises Act

Broker / Consultant Compensation Disclosure

What
Obtain a services-compensation disclosure from brokers / consultants

How
The brokers / consultants prepares and delivers a compensation disclosure to plan fiduciary

Who
Plan fiduciaries of fully insured and self-insured ERISA governed group health plans

When
On or after **December 27, 2021**. The compensation disclosure should be presented prior to engaging the broker / consultant to perform services or any renewal / extension of that relationship.
(Note, this timing does not necessarily tie to the plan year or policy renewal date.)

- This disclosure is different from the information included on the Form 5500 because it contains compensation not disclosed on Schedule A; it will look different; it is provided in advance; and it applies to all ERISA-covered clients.
- If the fiduciary does not receive the disclosure, it should request one. If no response in 90 days, the fiduciary must report broker / consultant to the DOL to avoid a prohibited transaction.

Prescription Drug Reporting- RxDC Report Section 204

Which plans are subject to reporting?

Grandfathered and non-grandfathered self-insured, level funded and insured medical plans report prescription drug and health plan cost information to HHS, DOL and Treasury Department.
HRAs, HSAs and health FSAs are exempt. TPAs/PBMs and insurance carriers may report on behalf of the reporting entity, although employers with carve-out PBM arrangements found this challenging.

What do they report?

- Information about the plan year, its enrollment,
- Employer / employee premiums and employee cost-sharing information and other general plan information,
- 50 most frequently dispensed brand drugs,
- 50 costliest drugs,
- 50 drugs with the most year-over-year increase in expenditures
- RX rebate information

When

June 1, 2024 for the 2023 reporting year. Plans report on a calendar year basis regardless of their plan year.

Prescription Drug Reporting –RxDC Report Year 3

2023 Plan Year Reporting – June 1, 2024!

RxDC instructions for 2023 reporting have not been published. Undergoing review by the Agencies
(DOL, HHS and Treasury)

- All plans will be **required to use the Health Insurance Oversight System *("HIOS")* to report the 2023** data.
  - Special "**email relief**" allowed for the 2020-2021 plan year reporting **will not be allowed for the 2022 or later years.**
- Very likely that carriers in the fully-insured market will report the D1 files, which contain employee prescription drug cost data, and the P2 group health plan list data directly to CMS, employers are required to complete questionnaire by the deadline specified by the carrier.
- Based on this past year's experience, it is critical to **coordinate data collection and reporting efforts** of carriers, TPAs, and PBMs early in order to meet the **deadline June 1, 2024**.

Required Action: Confirm is TPA, PBM or medical insurance carrier will be completing the RxDC reporting requirements on behalf of the plan. If the TPA,PBM or will not report on the plan's behalf be prepared to report by June 1,2024.

Gag Clause – Attestation Requirements

Purpose: Prohibiting health plans from entering contracts with TPAs, network and service providers or others that inhibit a plan's right to know cost or quality of care information.

When: December 31,2023, reporting for 2021,2022 and 2023 calendar years

What must the plan attest to:

1. Restrictions on the disclosure of provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage;
2. Restrictions on electronic access to de-identified claims and encounter information or data for each participant, beneficiary, or enrollee upon request, and
3. Restrictions on sharing information or data described in (1) and (2), or directing that such information or data be shared, with a business associate, as defined in 45 CFR 160.103, consistent with applicable privacy regulations.

How is the attestation submitted?

Via the HIOS site https//hios.cms.gov/HIOS-GCPCA-UI

Action Item: Confirm if your medical insurance carrier, medical TPA and PBM will be filing the gag attestation on behalf of your group health plan or if you will have to report on behalf of your plan

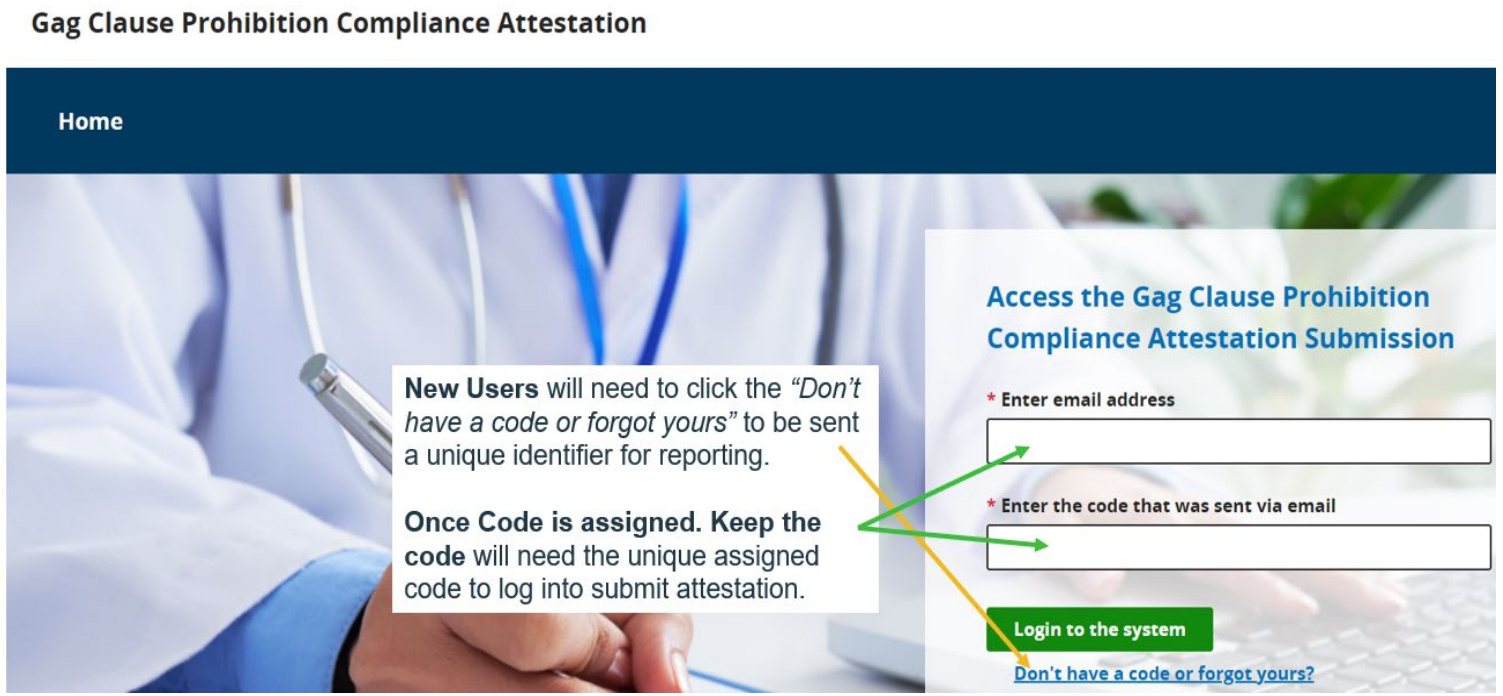
Gag Clause – Attestation Requirements

Which plans are required to comply with the attestation requirements?

Entities Required to Attest	Plan Exempt from the Attestation
○ Individual health insurance ○ Fully insured group health insurance plans *(carrier is the reporting entity for all group health plans including grandfathered plans)* ○ Self-insured and level funded group health plans sponsored by: • Church plans • Grandfathered plans • Non-federal governmental plans sponsored by state and local governments	○ HRAs, ICHRAs ○ Group health plans offering excepted benefits including: • Hospital indemnity or other fixed indemnity plans • Disease specific insurance • Dental, vision and Long-term care • Short-term duration insurance • Medicare and Medicaid plans • Basic Health Program Plans

How to Complete the Attestation

If you have been notified that your TPA, PBM or insurance carrier will not complete the attestation on your behalf, proceed to attest on behalf of your group health plan.



Reference Links:

[Frequently Asked Questions]

[Instructions for submitting the GCPCA]

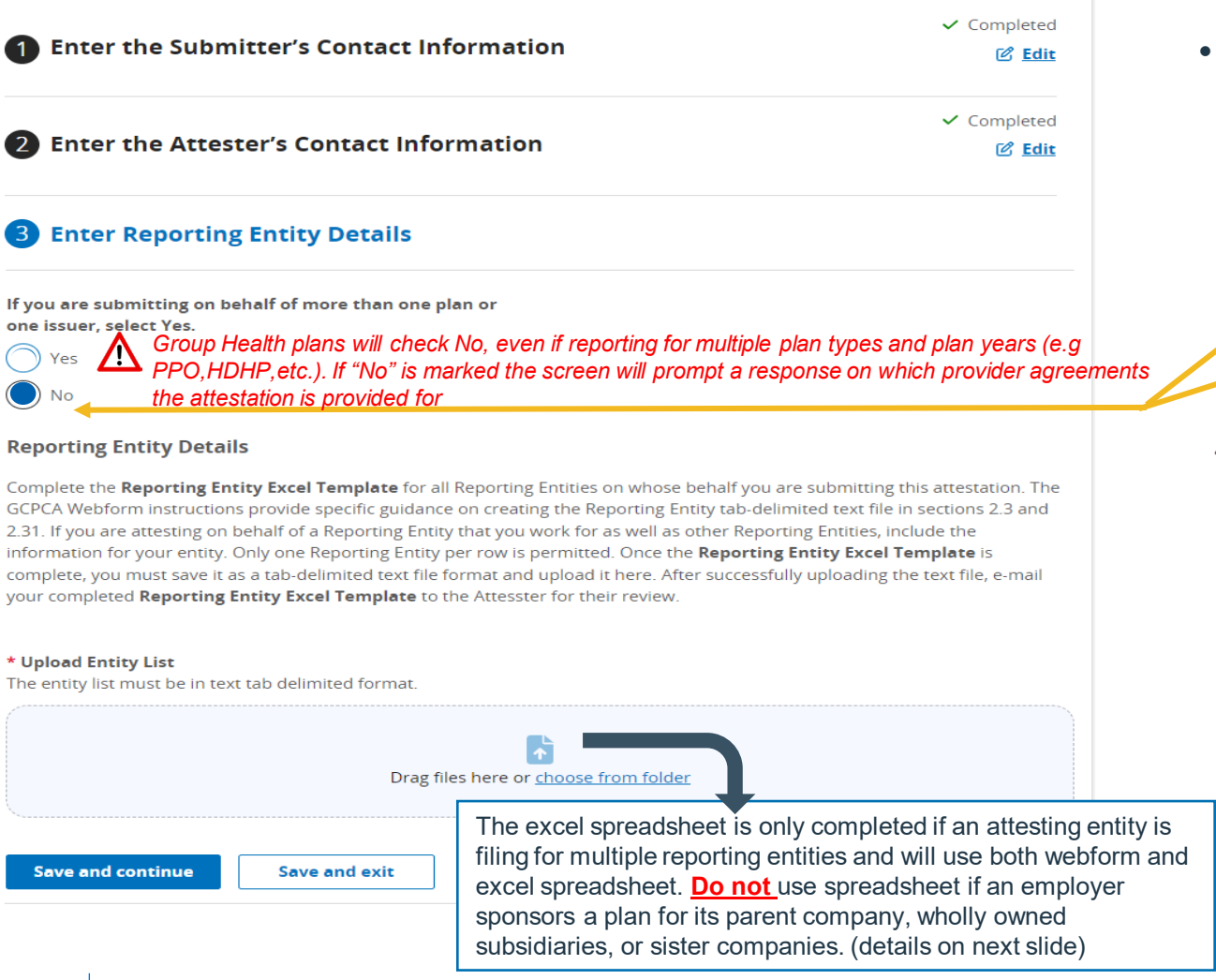
[User Manual for submitting the GCPCA]

[GCPCA Reporting Entity Excel Template]

★ [Gag Clause Attestation | Welcome! (cms.gov)]

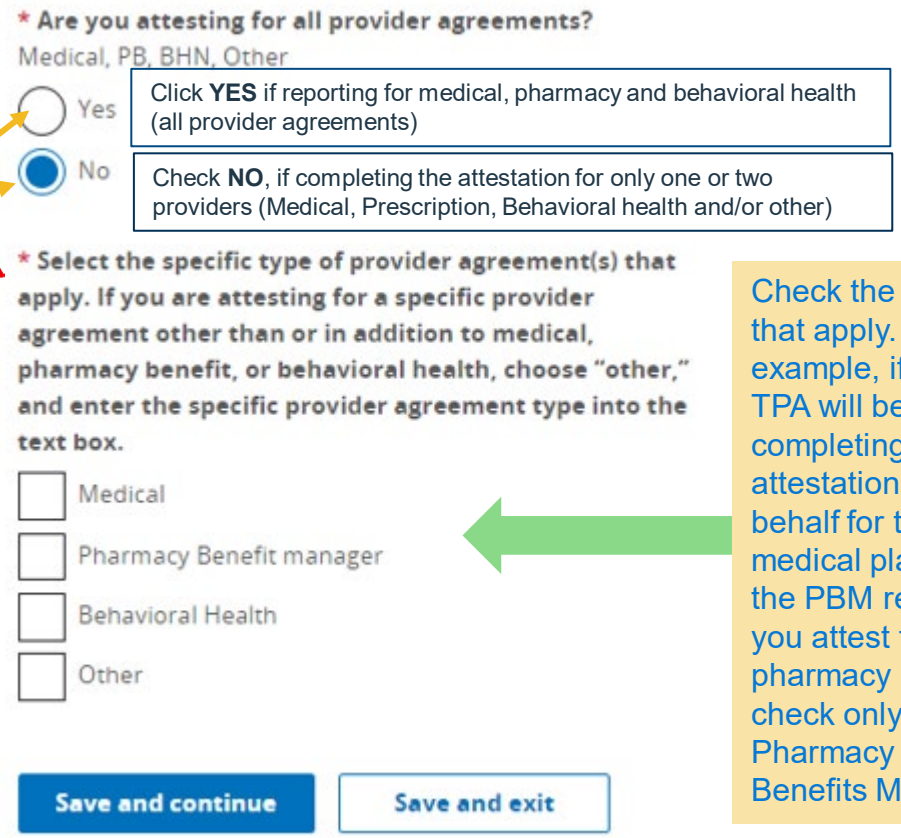
An email will be sent within 5 minutes from the HIOS_Submissions@cms.hhs.gov with a unique code

Attestation Submission | Reporting Entity Details



The excel spreadsheet is only completed if an attesting entity is filing for multiple reporting entities and will use both webform and excel spreadsheet. **Do not** use spreadsheet if an employer sponsors a plan for its parent company, wholly owned subsidiaries, or sister companies. (details on next slide)

- Will be or will not be attesting for all agreements; will need to mark accordingly



Check the box(es) that apply. For example, if the TPA will be completing the attestation on your behalf for the medical plan, but the PBM requires you attest for pharmacy benefits check only Pharmacy Benefits Manager.

Attestation Submission | Review & Submit

4 Review Submission and Attest

Submitter contact information

Submitter first and last name	Darcie Turner
Submitter position title	Vice President, Human Resources
Submitter e-mail address	Darcie.Turner@ ABC company.com
Submitter phone number	(916) 456-9089
Submitter employer name	ABC Company

- Review Submitter contact information (example above)
- Verify the Entity Type which is being attested
- Check that all is true, enter full name and the form will date stamp
- Click Submit

5 Verify the entity type(s) you are attesting on behalf of

You must, at a minimum, select that you are either attesting on behalf of a group health plan or insurance issuer. If you are attesting on behalf of both a group health plan, whether fully insured or self-funded, and an issuer of individual health insurance coverage, check both boxes.

Group health plans, including non-federal governmental plans, and health insurance issuers offering group health insurance coverage

I attest that, in accordance with section 9824(a)(1) of the Internal Revenue Code, section 724(a)(1) of the Employee Retirement Income Security Act, and section 2799A-9(a)(1) of the Public Health Service Act, the group health plan(s) or health insurance issuer(s) offering group health insurance coverage on whose behalf I am signing will not enter into an agreement, and has not, subsequent to December 27, 2020, entered into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the group health plan(s) or health insurance issuer(s) from —

1. Providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage;
2. Electronically accessing de-identified claims and encounter information or data for each participant, beneficiary, or enrollee in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Porta
   Genetic Information Nondiscrimination Act
   including, on a per claim basis —
   a. Financial information, such as the allov
      provider contract;
   b. Provider information, including name a
   c. Service codes; or
   d. Any other data element included in cla
3. Sharing information or data described in ite
   as defined in section 160.103 of title 45, Cod
   privacy regulations promulgated pursuant t

I'm attesting on behalf of group health plans, i
plans, and health insurance issuers offering gr

Attest your submission

I attest that I have the authority to bind the plan(s) or issuer(s) entered/uploaded in the entity attestation details.

I attest that all information in this submission is accurate.

* **Please enter your full name to sign this attestation.**

Signed submission date
07/18/2023 09:21 AM

Submit Start over

Submission successful

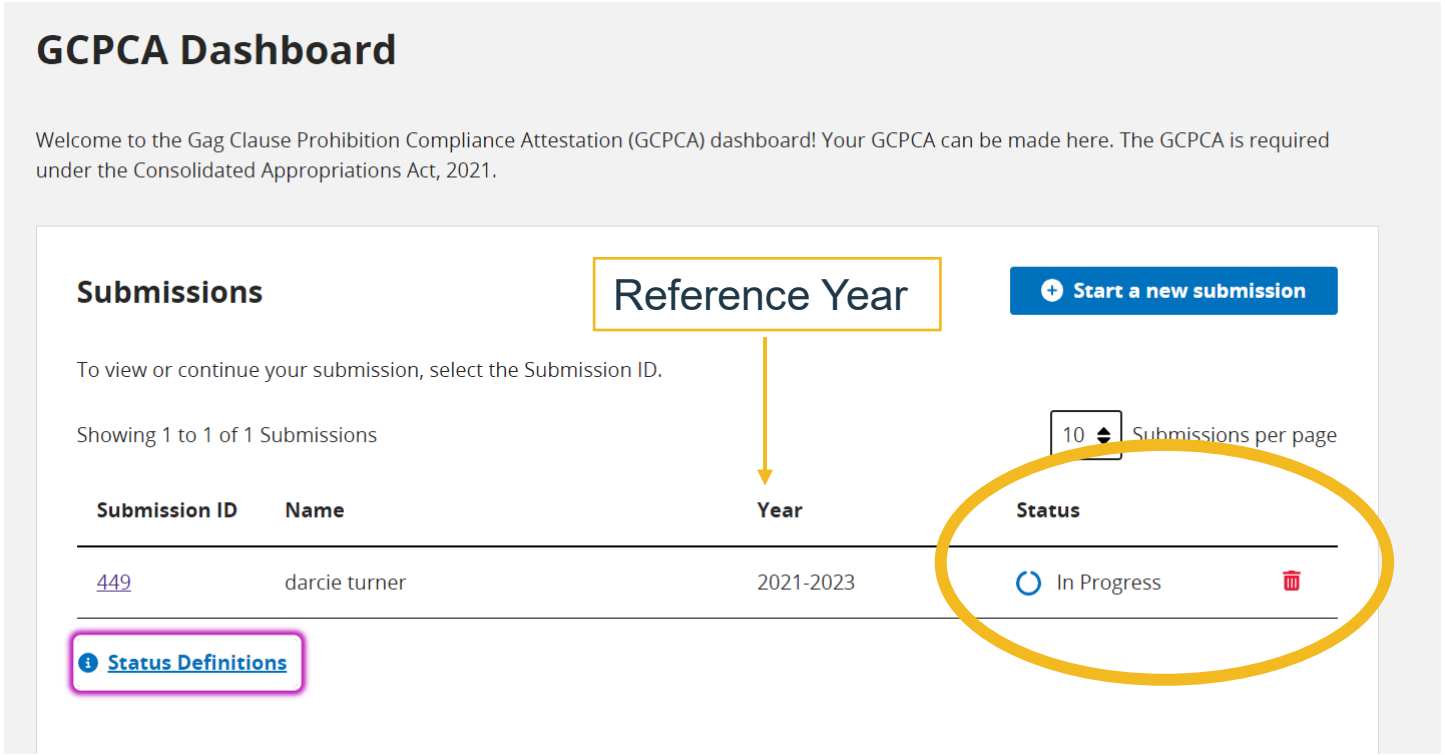
Excellent work, you have submitted **Test Insurance Entity Gag Clause Prohibition Compliance Attestation Information** on **02/10/2022** at **2:10 PM**

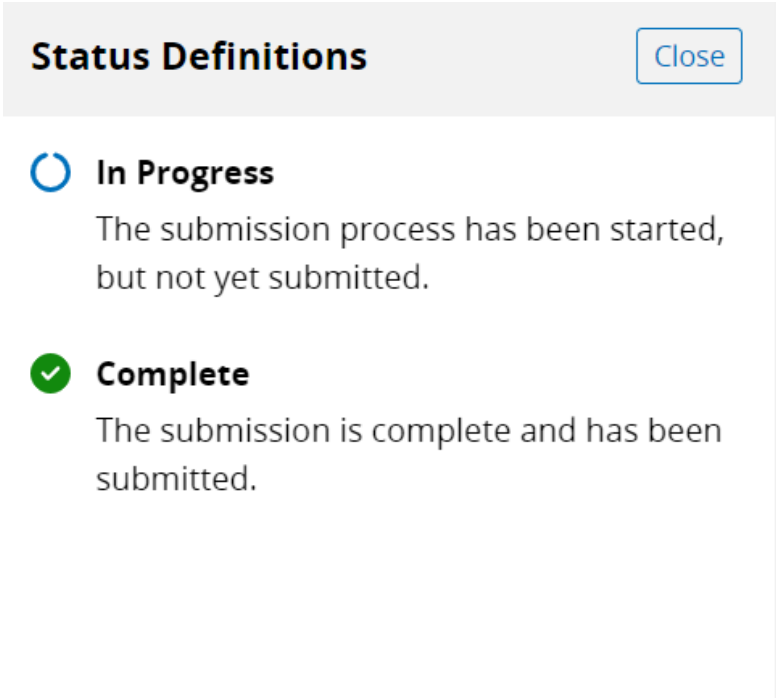
Return to dashboard Your submission receipt

Note: For GHP's, the attester and submitter are usually the same person

Submission Status

How to know if you submitted your attestation?





GCPA Resources

- If you have questions about submitting your Gag Clause Prohibition Compliance Attestation, contact the Help Desk at 1-855-267-1515 or CMS_FEPS@cms.hhs.gov. Include “GCPCA” in the subject line for faster service.

- **Other Resources**

  Frequently Asked Questions

  Instructions for submitting the GCPCA

  User Manual for submitting the GCPCA

  Health comp Reporting Entity Excel Template

  Gag Clause Attestation | Welcome! (cms.gov)

Acronym	Definition
CAA	Consolidated Appropriations Act
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
CSV	Comma-Separated Values
FEHB	Federal Employees Health Benefits
HIOS	Health Insurance Oversight System
IDM	Identity Management
MSD	Marketplace Service Desk
PBM	Pharmacy Benefit Manager
GCPCA	Gag Clause Prohibition Compliance Attestation
TPA	Third Party Administrator

No Surprises Act

"No Surprises Act" – effective January 1, 2022 for providers, for group health plans plan year beginning on or after January 1, 2022.- Purpose: Protect plan participants from receiving surprise medical bills from out-of-network *(OON)* providers requiring more money from the patient after the planhas paid its part

NEW- IDR Process suspended as of 8/3/23 for new disputes, 2022 disputes and disputes prior to 8/8/23 that were paid can proceed. (Texas Medical Assn. v. HHS)

A health plan or carrier must apply thein-network *(INN)* rules for prior authorization and in-network cost-sharing for a patient who receives:

- Emergency services from an OON provider
- Non-emergency services from an OON provider at an INN facility, or
- OON air ambulance services

- OON provider is prohibited from balance billing the patient for any emergency services or air ambulance services and certain ancillary services provided by OON doctors at an INN facility *(e.g., anesthesia)*
- It implements an independent dispute resolution process if the health plan *(carrier or self-insured / level-funded plan)* and the healthcare provider fail to agree on the qualified payment amount for services rendered. IDR provisions extend to Grandfathered plans.

3

ACA Reminders and Updates

IRS Enforcement of ESRP- Letter 226J

Under the new Administration enhanced focus on ACA enforcement efforts from the IRS

IRS is currently auditing employer compliance with the **2020/2021 ESRP** provisions of the ACA

- Letters 226-J mailed to employers informing them of failure to comply with IRS 4980H(a) or (b) provisions
- Letter provides employer 30-days to respond to the inquiry
  - Employer agrees and pays penalty
  - Employer appeals the penalty and supports additional information with the appeal

Employer should file an extension with the IRS to appeal decision- fax request to the number that appears at on right-hand corner of letter. Will be granted a 30-day extension to appeal decision.

➡ **NEW:** Letters 226J question if a plan is deemed to be affordable under the ACA, new codes used in Form 14765. Employer is required to show proof that plans are deemed to be affordable.

2024 ACA Affordability

Affordability of Employee-only Coverage

Lowest cost plan that is **minimum value. Safe harbor decreased from 9.12% to 8.39%** based on one of the three safe harbors:

1 Rate of Pay

(Hourly rate of pay x 130)
8.39% Maximum amount to charge for employee-only coverage.

Example: An employee earning $16.00 an hour in 2023 cannot pay more than $189.70 per month if the plan is to be deemed affordable; however, in 2024, that same employee cannot pay more than $174.51.

2 Federal Poverty Level *(FPL)*

Calendar year plans must use **2023 FPL x 8.39% / 12** to assess affordability for 2023 *($14,580 x 8.39% / 12) =* ***$101.94*** *vs. the 2023 rate of* $103.28 per month.

- Non-calendar year plans- **TBD**

3 W-2 Safe Harbor

Use Box 1 of employee's W-2 earnings.
Must use projected 2023 income; amount cannot change throughout the year.

- Box 1 = gross earnings minus pre-tax deductions under a cafeteria plan and a 401(k) plan.

2024 Affordability Observations

Employers must use the new affordability safe harbor, 8.39% as of the first day of the plan year in 2024. For example, plans renewing on July 1,2024 can use the 2023 safe harbor until June 30,2024, as of July 1,2024 they will use 8.39%.

The affordability percentage of 8.39% for 2024 is the lowest it has ever been since the enactment of the ACA.

- 2024 Safe harbor is even lower than exchange income threshold of 8.5%
- Some employers may be forced to offer unaffordable coverage to their lowest income employees if they also face large renewals in 2024.
- Tribes may want to review other options such as the FEHBP if they renewal increases and decrease in affordability safe harbor becomes a financial burden to the tribe.

Employers who based 2023 affordability on the maximum allowable percentage will need to increase employer contributions to meet 2024 affordability.

2024 PFL safe harbor has not yet been released, therefore non-calendar year plans will have to determine in January 2024 if they also need to adjust their contributions or not due to the decrease in the affordability safe harbor.

Penalties Through the Years

		2017	2018	2019	2020	2021	2022	2023	2024
4980H(a) Penalty	**Annual Amount**	$2,260	$2,320	$2,500	$2,570	$2,700	$2,750	$2,880	$2,970
	Monthly Amount	$188.33	$193.33	$208.33	$214.17	$225.00	$229.16	$240.00	$247.50
	MEC Offer % of FT	95%	95%	95%	95%	95%	95%	95%	95%
	FT Headcount Reduction	30	30	30	30	30	30	30	30
4980H(b) Penalty	**Annual Amount**	$3,390	$3,480	$3,750	$3,860	$ 4,060	$4,120	$4,320	$4,460
	Monthly Amount	$ 282.50	$290.00	$312.50	$321.67	$338.33	$343.33	$360.00	$371.66
	Affordability Safe Harbor %	9.69%	9.56%	9.86%	9.78%	9.83%	9.61%	9.12%	8.39%
	FPL Annual Amount *(individual)*	$11,880	$12,060	$12,140	$12,490	$12,880	$13,950	$14,580	TBD

ACA Reporting

2024 reporting deadlines

- Distribute Forms 1095-C to employees: March 2, 2024 - **PERMANENT**
- File Forms 1095-B & -Cs with the IRS *(electronic required if filing more than 10 returns)*: April 1, 2024
- File **Forms 1095-B & -Cs** with the IRS *(paper if **filing less than 10 returns**)*: February 28, 2024

Employers who don't complete reporting on time must still complete ASAP

- Less than 30 days late – maximum penalty of $50 per form
- **More than 30 days late, but filed by August 1st – maximum penalty of $110 per form**
- Filed after August 1st – maximum penalty of $290 per form (2023 filings)

Must correct reporting errors within 30 days of filing- Enforcement in place for 2021 and 2022

IRS is no longer looking at good faith efforts to comply made by employers when assessing penalties

State Individual ACA Reporting Mandate Deadlines

Insurance carriers, self-funded *and* level-funded medical plans ***(ICHRAs, level-funded and MEC plans)*** **covering residents in 2024**

California

- 1095 C/B mailed to employees by **January 31, 2024**
- 1095 C/B filed with State of CA Franchise Tax Board by March 31, 2024
- File the State Healthcare MEC on paper if under 250 files; otherwise, must file electronically
- Mandated distribution deadline is not automatically extended to mirror the federal deadline.

Massachusetts

- Distribute Form MA 1099-HC annually to employees enrolled in their health plan no later than January 31, 2024
- Complete HIRD Form for Six (6) or more employees and submit each year on December 15th of the reporting year
- Will be required to file on MassTaxConnect (MTC) portal

New Jersey

- 1095 C/B to be distributed to employees by **March 2, 2024**
- File NJ-1095 form by **March 31, 2024**, with the New Jersey Division of Taxation Payroll Taxes and Wage Withholding Login (state.nj.us)

Rhode Island

- Forms 1095-C/B must be distributed to covered participants by **March 2, 2024**
- Forms 1095 C/B must be filed with the RI Division on Taxation by March 31, 2023, giving employers a two (2) month extension from the January 31, 2024, deadline.

Washington D.C.

- Employers that have Washington D.C. residence and have 50 or more employees
- Forms 1095-C/B must be distributed to covered participants as outlined by IRS, including any extensions
- 1095 C/B must be filed with the Office of Tax and Revenue no later than 30 days after the deadline established by the IRS to file returns, including extensions.
- Electronically submitted only D.C Office of Tax and Revenue (OTR) electronically through MyTaxDC

4

Other Reminders & Updates

Fixed Indemnity Excepted Benefits Coverage

Background: The IRS does not consider fixed indemnity policies to be MEC, as they are designed to pay a fixed amount directly to covered individuals following certain healthcare events as income replacement, not as medical coverage or reimbursement.

Proposed Rule: HHS proposed additional rules to prevent groups from offering fixed indemnity policies as an alternative or supplement to compliant medical coverage. Policies would have to comply with the following to remain excepted benefits:

- **Payment Criteria:** Fixed indemnity plans need to pay benefits regardless of medical services rendered, incurred expenses, severity of illness or injury, or type of treatment received.
- **Non-coordinated Benefit:** Policies must be offered as ***independent, non-coordinated coverage***. A policy offered alongside a group health plan with an exclusion of benefits is considered coordinated, even if there is no formal arrangement.
- **Tax treatment:** Fixed indemnity plans would no longer be included as part of the tax exclusion for employer-sponsored health insurance.

Takeaways: The focus is clearly on how policies are marketed and sold to groups and individuals. If finalized, policy review will become even more essential before implementation.

MHPAEA Proposed Rules Published

On July 25th, the tri-agencies issued new proposed rules addressing compliance with the Mental Health Parity and Addiction Equity Act *(MHPAEA)* and signaling an intent to implement major changes to the law. If finalized, the new requirements would include:

- Require health plans to review provider network data, namely IN and OON utilization, claims denials, time and distance data, and data around providers accepting new patients.
- Review MH/SUD claims data to evaluate if NQTLs are more restrictive with prior authorizations, medical management techniques, or narrower networks.
- Require health plans to use similar factors in setting OON payment rates for MH/SUD providers as they do for medical providers.
- Clarify the Departments' process for reviewing a plan's NQTL comparative analysis.
- In an additional technical release, the DOL requested comments on the type, form and manner of the data plans would be required to collect for NQTL analysis. The comment window is open for 60 days.

Takeaways: These rules are still at a proposed stage; therefore, groups should not be making any major changes to their MH/SUD benefits in response to this Information until the Departments issue final regulations.

California State Update

CA Long Term Care Insurance Update

- California Long Term Care Insurance (LTCI) Task Force continues to meet surrounding benefit plan design of the LTSS
- Last meeting was on September 21st, covering the development of the program which **is still in its infancy stage**
- Discussing 5 different plan designs and contributions

Plan Modeling examples include:

- Potential program projection period will be 75 year assuming effective date of January 1, 2025, and how funding will look according to effective dates *(i.e., 2026; 2027 and thereafter)*
- Contribution structure assessed will be based on waiver levels and caps
- Calculation of contribution allows for employer / employee paid portion flexibility
- Eligibility vesting requirements are still being assed such as:
  - Similar to WA Cares Fund, 500 hours worked *(per year)* requirement for vesting criteria
  - Earnings based requirement *(akin to Social Security)*

Other Considerations:

- What is the opt out option that will be available for California?
- What a level payroll tax vs. an aggressive tax rate would look like for contributions *(although they are focusing on a level tax contribution)*

Note: Employers can offer LTC plans to employees, however, cannot guarantee that their existing plan will meet the CA LTCi requirements as the plans designs **have not yet been finalized.**

We will continue to monitor developments and comment on them as appropriate

California State Update

CA Long Term Care Insurance Timeline

NEXT STEPS AND TIMELINE

October 3rd Actuarial Subcommittee meeting regarding draft Actuarial and feedback due by Oct 13th. Will then release to public in November

1. Following Task Force Meeting #21, Oliver Wyman will issue a questionnaire asking Task Force members if they recommend any changes to the five Program designs based on the preliminary actuarial analysis results
2. A supplement to the Feasibility Report will be included in the Actuarial Report, documenting additional Task Force recommendations, if applicable

Q&A

Thank You

For more information visit **hubinternational.com**