IslerDare PC

Employee Benefits Update March 21, 2022

Roundup of Recent Developments for Health and Welfare Plans

EXECUTIVE SUMMARY

There have been a variety of developments recently related to health and welfare benefits and group health plans that we want to bring to your attention. This Employee Benefits Update addresses the following:

- The extension of certain deadlines due to the continuation of the national COVID-19 emergency
- Plan coverage of over-the-counter at-home COVID-19 tests
- Compliance with nonquantitative treatment limitations requirements of the Mental Health Parity and Addiction Equity Act
- New broker and consultant compensation disclosures
- An increase in PCORI fees
- New women's preventive services guidelines
- A temporary extension of first-dollar coverage for telehealth and remote care services under high-deductible health plans
- The method for calculating qualifying payment amounts in 2022
- The addition of health plan compliance for Department of Defense contractors

IMPORTANT DATES

March 31:

- File ACA information reporting returns (if filing electronically)
- File Form 5330 for excise taxes related to excess 2020 plan year ADP/ACP contributions that were not timely corrected in 2021 (unless extension filed)
- File Retiree Drug Subsidy reconciliations with CMS for 2020 plan year
- Submit ACA information returns if employer operates in CA, RI, and NJ

April 1:

- Initial required minimum distributions (RMDs) due from retirement plans to participants who turned 72 or terminated employment (whichever is later) in 2021

Extension of Certain Deadlines due to Continuation of the National COVID-19 Emergency

On February 18, 2022, President Biden officially extended the national emergency related to the COVID-19 pandemic, which was first declared effective March 1, 2020 and was set to expire March 1, 2022. This extension means that various deadlines related to your health and welfare plans continue

to be extended for one year (or, if earlier, 60 days from the end of the national emergency), but the tolling, or extension, period applies on a per person basis. Most notably, the extensions apply to the following:

- The deadline for an individual to elect COBRA;
- The deadline for an individual to pay COBRA premiums;
- The deadline for an individual to notify a group health plan of a COBRA qualifying event or determination of disability;
- The deadline for group health plans to provide COBRA election notices;
- The deadline for an individual to elect HIPAA special enrollment; and
- The deadlines to file benefit claims, appeals, and requests for external review.

✓ ***Action Steps for Employers:*** Because these extensions apply on a per-person basis, the administration of them can be tricky. Plan sponsors should work with your third-party service providers, such as your group health plan recordkeepers, enrollment vendors, and COBRA administrators, to confirm that they have modified their systems and procedures to fully comply with these extended deadlines.

Plan Coverage of At-Home COVID-19 Tests

The Departments of Health and Human Services, Labor and the Treasury have issued two sets of FAQs to clarify that individuals who purchase over-the-counter ("OTC") COVID-19 diagnostic tests during the public health emergency may seek reimbursement from their plan or insurer for purchases on or after January 15, 2022, regardless of whether the tests have been ordered by a healthcare provider. This coverage must be provided without imposing any cost-sharing requirements, prior authorization, or other medical management requirements.

The new guidance encourages, but does not require, plans and insurers to provide "direct coverage" for OTC tests at the point-of-sale by reimbursing vendors directly and without requiring participants to submit claims for reimbursement. In addition, a plan can limit reimbursement for tests purchased at non-preferred pharmacies or other retailers to the lesser of: (1) the actual price per test; or (2) $12 per test (for multipacks, reimbursement remains $12 for each test within the pack) if it follows certain "safe harbor" requirements, including providing direct coverage for tests through at least one in-person mechanism and at least one direct-to-consumer shipping program and having adequate access to tests through the direct coverage program (taking into account supply shortages). Following the safe harbor will also result in no enforcement action being taken against a plan for its coverage of OTC tests. If the safe harbor requirements are not met, the plan must pay the full cost of the tests, including those purchased from non-preferred pharmacies or retailers. Additionally, a plan may limit the number of OTC tests it pays for during the public health emergency to no fewer than eight tests per 30-day period.

The FAQs also clarify that plans should notify participants not to seek reimbursement from account-based plans, such as health flexible spending accounts (health FSAs), health reimbursement arrangements (HRAs), or health savings accounts (HSAs), or use debit cards associated with account-based plans, to purchase OTC tests for which they plan to seek reimbursement from the group health plan, because essentially this would be "double-dipping".

✓ ***Action Steps for Employers:*** Sponsors of group health plans should confirm with their insurance carrier or third-party administrator, as applicable, that coverage complies with these OTC coverage test rules, and also notify your plan participants about this benefit, if you have not already done so.

Compliance with Nonquantitative Treatment Limitations Requirements of the Mental Health Parity and Addiction Equity Act

On January 25, 2022, the Departments of Labor, Health and Human Services, and the Treasury released their 2022 Annual Report to Congress on the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), which detailed their enforcement findings after auditing plans for compliance with the nonquantitative treatment limitations (NQTL) requirements of the MHPAEA.

As background, group health plans must be able to provide, upon request from the DOL, a comparative analysis to demonstrate compliance with NQTL requirements. Generally, a NQTL is a limitation on the scope or duration of benefits for treatment, and under the MHPAEA, these cannot be applied more stringently on mental health and substance abuse treatment benefits than on medical or surgical benefits in the same classification. The 2022 Annual Report highlighted that the comparative analyses reviewed by the DOL thus far did not sufficiently demonstrate compliance with NQTL requirements.

- ✓ ***Action Steps for Employers:*** In light of the findings of the 2022 Annual Report and the uptick in DOL audits focused on NQTL compliance, all group health plans should work with their carriers or third-party administrators and be prepared to provide a comprehensive comparative analysis that sufficiently addresses NQTL requirements. The DOL has published a MHPAEA self-compliance tool to aid with the analysis, and Section F of the tool specifically addresses the NQTL requirements.

New Broker and Consultant Compensation Disclosures

The Consolidated Appropriations Act, 2021 requires that service providers (and their affiliates or subcontractors) providing brokerage or consulting services to group health plans and "excepted benefit" plans (such as those providing limited scope dental and vision benefits) disclose to plan sponsors, in writing, any and all direct or indirect compensation they receive for providing services to the plan, if they reasonably expect to receive at least $1,000 in direct or indirect compensation for those services.

The new disclosure requirement applies to service providers who extend or renew existing contracts or arrangements, or enter into new contracts, after December 27, 2021.

- ✓ ***Action Steps for Employers:*** Plan sponsors should confirm that they have received and reviewed such disclosures from the brokers or consultants for their health and welfare plans, to ensure the health plan's arrangement with the broker or consultant is "reasonable." Additionally, plan sponsors have a responsibility to report to the DOL any service provider who fails to provide this disclosure.

Increase of PCORI Fees

The IRS has raised the fee that insurers or sponsors of self-insured health plans pay annually to fund the federal Patient-Centered Outcomes Research Institute (PCORI) trust fund. For plan years that end on or after October 1, 2021, and before October 1, 2022 (including calendar year plans), the fee is $2.79 per person covered by the plan, up from $2.66 a year earlier. Self-insured employers pay the annual PCORI fee directly to the IRS, and for fully insured employers, the fee is paid by the insurance provider.

- ✓ ***Action Steps for Employers:*** If your group health plan operates on a calendar year and ended on December 31, 2021, you will need to file IRS Form 720 and pay your annual PCORI fee of $279 per covered person, no later than August 1, 2022 (since the due date of July 31st falls on a weekend this year).

HRSA Approved New Women's Preventive Services Guidelines

The HHS Health Resources and Services Administration (HRSA) recently issued updated existing women's preventive services guidelines under the Affordable Care Act, to require the following services to be covered without cost sharing by non-grandfathered private health plans:

- Comprehensive lactation consultation and double electric breast pumps for breast-feeding women;
- The full range of women's contraceptives listed in the recently updated FDA Birth Control Guide;
- Obesity counseling for women aged 40-60 years old;

- Screening for HIV infection for all adolescent and adult women aged 15 and older at least once in their lifetime, and risk assessment and prevention and education beginning at age 13; and
- pre-pregnancy, prenatal, postpartum and interpregnancy well-woman visits.

Health plans have a year to adopt the changes and will need to provide the required coverage for plan years beginning on or after December 30, 2022.

✓ ***Action Steps for Employers:*** As plan sponsors begin to work on 2023 health plan design, features, and costs, they should engage with their insurance carriers (for fully-insured plans) or third-party administrators (for self-funded plans) to ensure that the 2023 plan benefits will include these new preventive care services, and that sufficient information is provided to their plan participants about these new benefits.

Temporary Extension of Telehealth Services Under HDHPs for April – December 2022

On March 15, 2022, President Biden signed into law a comprehensive spending and Ukrainian relief package, known as the Consolidated Appropriations Act, 2022, which permits high-deductible health plans (HDHPs) to provide first-dollar coverage for telehealth and other remote care services for the months of April-December 2022, even if the services are not preventive care or related to COVID. This means that telehealth and remote care services can be covered by a HDHP before an individual's deductible has been satisfied. In addition, the new law provides that telehealth and remote care services are disregarded when evaluating the eligibility of a participant in a HDHP to contribute to a Health Savings Account.

✓ ***Action Steps for Employers:*** Sponsors of HDHPs should work with their insurance carriers (for fully-insured plans) or third-party administrators (for self-funded plans) to determine whether this optional feature will be implemented so that appropriate communications of this additional benefit can be provided to plan participants.

Method of Calculating Qualifying Payment Amount in 2022

As we previously described in a prior newsletter, under the No Surprises Act, generally, an out-of-network provider, facility, or provider of air ambulance services can no longer balance bill the patient for the excess amount, and patient cost sharing is limited to in-network levels. The No Surprises Act provides for negotiation between the group health plan or group or individual health insurance issuer and the provider, facility, or provider of air ambulance services to determine the amount to be paid by the plan or issuer, if any, which takes into account the qualifying payment amount ("QPA") for the item or service. Our most recent newsletter discussed these payment determinations as related to air ambulance claims. The QPA for a specific item or service is the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service furnished by a provider in the same or similar specialty in a specific geographic region, adjusted annually for inflation.

The IRS recently issued Notice 2022-11 providing guidance on calculating the QPA for an item or service furnished in 2022 for which a plan or issuer does not have sufficient information to calculate the median of the contracted rates in 2019. In this instance, the plan or issuer must calculate the QPA by multiplying the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, drawn from any eligible database, by the percentage increase of 1.0299772040. Similarly, in the case of a newly covered item or service furnished in 2022, when 2022 is the first coverage year for the item or service with respect to the plan or coverage, the plan or issuer must calculate the qualifying payment amount by multiplying the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in 2021, drawn from any eligible database, by the percentage increase of 1.0299772040.

✓ ***Action Steps for Employers:*** Sponsors of health plans should work with their insurance carriers (for fully-insured plans) or third-party administrators (for self-funded plans) to confirm compliance with this new guidance on calculating QPAs.

Added Health Plan Obligations on Department of Defense Contractors

The Consolidated Appropriations Act, 2022 signed into law on March 15, 2022 provides that businesses contracting with the Department of Defense ("DOD") to perform functions currently performed by DOD civilian employees must pay employer health plan contributions for workers that will perform the contracted services at the same rate as DOD would pay for services performed by its civilian employees. This added health care requirement adds to the long list of requirements for DOD contractors.

- ✓ ***Action Steps for Employers:*** DOD contractors and subcontractors should review practices and documentation to confirm compliance and readiness to defend a potential audit or enforcement action.

Additional Information

For additional information about these health and welfare plan topics, or any other employee benefits matter, please contact any member of our Employee Benefits and Executive Compensation Practice Group listed below.

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