Legal Consulting Update

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Prepared by Health Solutions

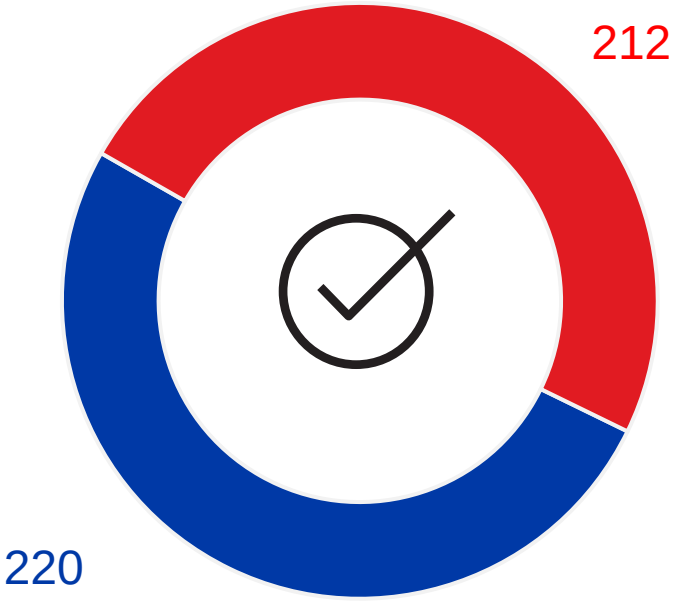
Presentation to iCEBS Benefits Day (Pittsburgh)

Empower Results®

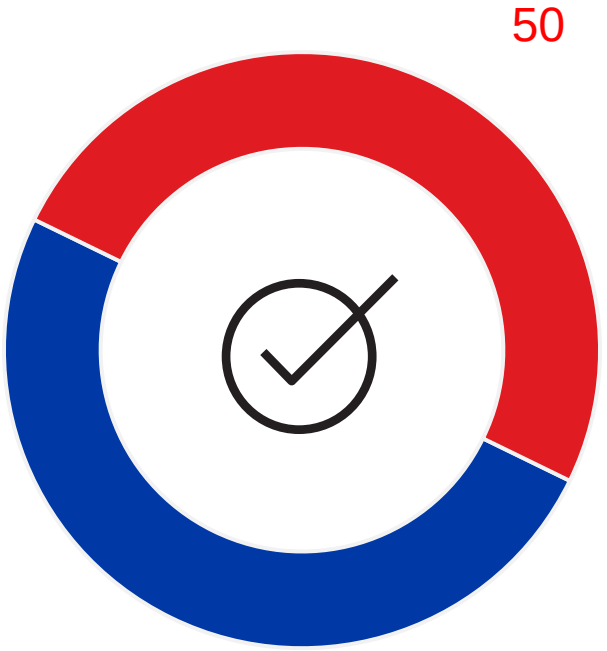
The Presidency, Congress, and Health Care

117th Congress

U.S. House of Representatives[1]



U.S. Senate



[1] 3 vacancies

Biden Health Care Priorities

Protect and Expand the Affordable Care Act (ACA)

Supports

- **Extending** expanded health insurance tax credits under the **American Rescue Plan**, as part of the American Families Plan

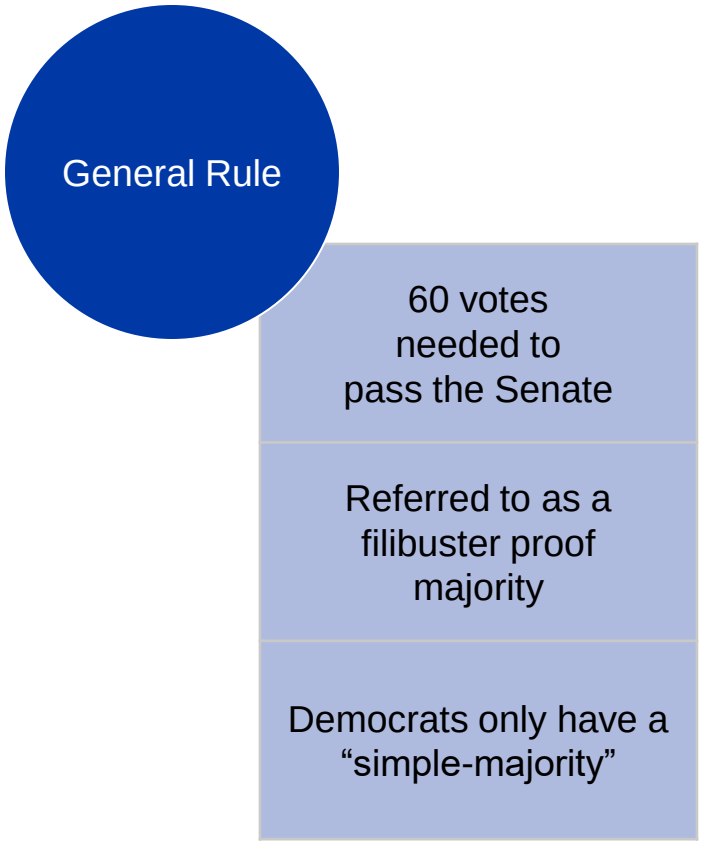
Other Goals

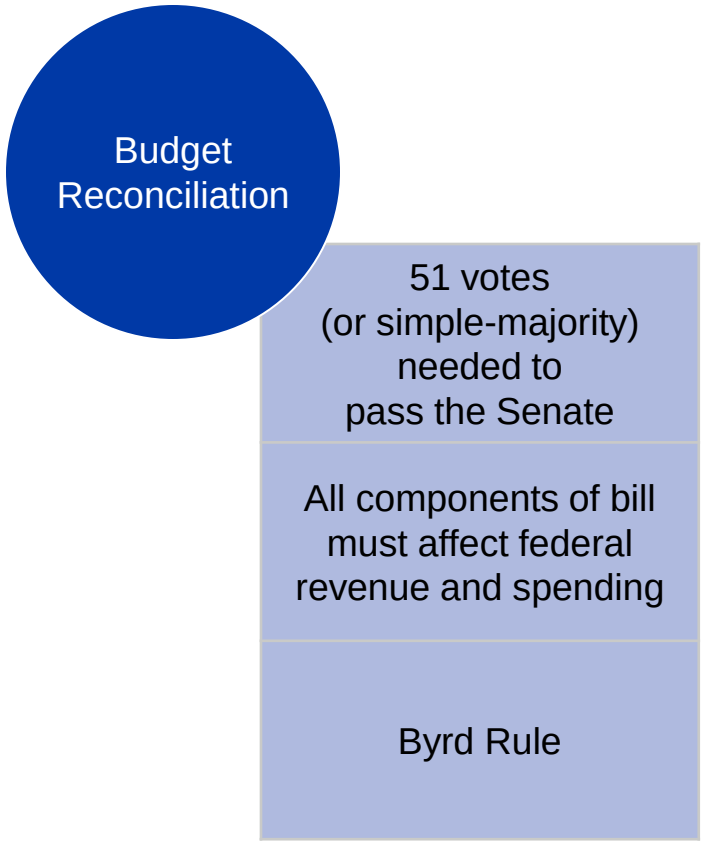
- Adding public option to ACA exchanges
- Allowing Medicare buy-in at age 60
- Reducing prescription drug (Rx) prices (Medicare to negotiate directly) [HR3]
  - Would like to expand similar pricing to employers based on proposal from 9/9/2021 but unlikely to meet Reconciliation rules
- Expanding Medicaid (Republican states)

*Released on White House website on **04/28/2021** as part of Build Back Better*

Biden Agenda

Legislation Required





Health & Welfare Topics at Play

- Need to reduce package from $3.5 trillion to as little as $1.9 trillion while staying united
- Revenue raising:
  - Tax increases (e.g., personal, corporate, and capital gains)
    - Repeal of SALT Cap?
  - Allow CMS to directly negotiate price of certain drugs with Rx manufacturers & align closer to price in other countries
- Spending:
  - Expand Medicare to include dental (2028), hearing (2023), and vision (2022)
    - Income limits? $40,000 or less?
  - Medicaid expansion
    - 3-year sunset?
  - 12 weeks of paid family and medical leave
    - Decrease no. of weeks?
    - Phase in
    - Limit to parental leave

Affordable Care Act Transparency

Price Transparency Overview

Two separate pieces of legislation address price transparency, but with some overlap: The ACA and Consolidated Appropriations Act (CAA)

The ACA required plans to address price transparency—final regulations in FR 11/12/2020; FAQs Part 49 (8/20/2021)

DELAYED until 7/1/2022 for medical (or later if PY is later); Rx until guidance

Plans and insurers must publicly disclose through machine readable files:

1. Negotiated rates for in-network providers for covered items and services;
2. Historical Allowed amounts and billed charges for out-of-network (OON) providers; and
3. Prescription drug file

1/1/2023 and 1/1/2024

Internet-based self-service tool that will disclose to participants upon request specific cost-sharing information for covered items and services from providers

1. Phased implementation beginning with PY on or after 1/1/2023 with respect to 500 items and services
2. Full implementation PY on or after 1/1/2024

ACA Transparency Rule—Responsible Party

Who Is Responsible for Disclosure of Cost-sharing Information?

The requirements apply to both group health plans and health insurance issuers

Fully-Insured. If the group health plan is insured, the plan satisfies the requirements if the issuer offering the coverage is required to provide the information pursuant to a written agreement between the plan and the issuer.

- If the issuer fails to provide the required disclosures, then the issuer (not the plan) would violate the requirements

Self-Insured. Self-insured group health plans are technically liable for compliance with these requirements, specifically for provision of the self-service tool and the publication of the machine-readable rate files.

- Plans are permitted to enter into written agreements with a pharmacy benefit manager (PBM) or other vendor to provide the disclosures, but the plan is liable for a violation if the third party fails to do so
- Service agreements/contracts should be reviewed to determine if updated language is needed, including indemnification language if vendor agrees to provide and fails to do so
- Plans will also need to determine if service providers will charge additional costs for these services

Consolidated Appropriations Act of 2021 (CAA, 2021)

Consolidated Appropriations Act of 2021

- Enacted on 12/27/2020 with varying effective dates
- Health care topics included:
  - Additional flexibility for FSAs
  - Legislation on surprise medical billing
  - Price transparency and disclosure rules
  - Reporting rules on pharmacy benefits and prescription drug costs
  - Extension of student loan repayment programs
  - Mental health parity rules

CAA Price Transparency and Cost Disclosure Rules

Application to Grandfathered Health Plans

- FAQs Part 49 (issued 8/20/2021), No. 11
- Clarifies that the CAA, 2021 transparency and related provisions apply to grandfathered and non-grandfathered group health plans

CAA Price Transparency and Cost Disclosure Rules

Price Comparison Tool

- FAQs Part 49 (issued 8/20/2021), No. 3
- Initially effective as of Plan Year beginning on or after 1/1/2022 but now DELAYED
- Largely duplicative with ACA transparency requirement, except for mandate to provide transparency information over the telephone
  - Will now be aligned with the ACA transparency requirements that will be effective as of Plan Years beginning on or after 1/1/2023

CAA Price Transparency and Cost Disclosure Rules

In-Network and Out-of-Network (OON) Deductibles and Out-of-Pocket (OOP) Limits on Insurance ID Cards – Action

- FAQs Part 49 (issued 8/20/2021), No. 4
- Initially effective as of Plan Year beginning on or after 1/1/2022 but now “good faith compliance period”
- For example, Departments will not deem a plan to be out of compliance with ID requirements if the plan includes on any physical or electronic ID cards the following:
  - Applicable major medical deductible and OOP maximum
  - Telephone number and website address for individuals to seek consumer assistance and access additional applicable deductibles and OOP limits
  - Additional deductibles and OOP maximum limits could also be provided on a website that is accessed through a Quick Response code (QR code) on the participant’s card or through a hyperlink in the case of a digital ID card

CAA Price Transparency and Cost Disclosure Rules

Advanced Explanation of Benefits (EOB)

- FAQs Part 49 (issued 8/20/2021), No. 6
- Initially effective as of Play Year beginning on or after 1/1/2022 – DELAYED until regulations are issued
- Generally required an Advanced EOB that must include:
  - Network status of provider or facility
  - The contracted rate for the item or service
  - Good faith estimate received from the provider
  - Good faith estimate of the amount the plan is responsible for paying and the amount of any cost-sharing for which the individual would be responsible for paying with respect to the good faith estimate
  - Disclaimers on medical management techniques

CAA Price Transparency and Cost Disclosure Rules

Prohibition on Gag Clauses & Price & Quality Data

- FAQs Part 49 (issued 8/20/2021), No. 7

- Initially effective as of 12/27/2020 – Good Faith Compliance until Agencies issue implementation guidance and require submission of attestations of compliance in 2022

- Prohibits plans and issuers from entering into an agreement with a provider, TPA, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from:
  - 1. Providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, or otherwise eligible employees
  - 2. Electronically accessing de-identified claims and encounter data for each participant
  - 3. Sharing such information, consistent with applicable privacy regulations

CAA Price Transparency and Cost Disclosure Rules

Protecting Patients and Improving the Accuracy of Provider Directory Information

- FAQs Part 49 (issued 8/20/2021), No. 8

- Initially effective as of Plan Years beginning on or after 1/1/2022 – good faith period

- Plan and issuers must establish a process to update and verify the accuracy of provider directory information and to establish a protocol for responding to requests by telephone and electronic communication from a participant about a provider's network participation status
  - If participant receives assistance from an out-of-network provider and was provided inaccurate information in the provider directory or response protocol (i.e., that the provider was in-network when it was not), then the plan or issuer cannot impose cost-sharing amount that is greater than the cost-sharing amount that would be imposed for items and services furnished by a participating provider and must count such amounts towards the deductible and OOP maximum

- Rule making is delayed; however, good faith application of this rule applies on or after 1/1/2022 (i.e., plan/issuer must comply with information in blue)

CAA Price Transparency and Cost Disclosure Rules

Balance Billing Disclosure

- FAQs Part 49 (issued 8/20/2021), No. 9 (Surprise Billing)
- Initially effective as of Plan Years beginning on or after 1/1/2022 – good faith period
  - See model notice & slide on Surprise Billing Notice requirements

CAA Price Transparency and Cost Disclosure Rules

Continuity of Care

- FAQs Part 49 (issued 8/20/2021), No. 10
- Initially effective as of Plan Years beginning on or after 1/1/2022 – good faith period
  - If an individual has benefits under a group health plan, statute required ability to have coverage in-network for 90 days when provider or facility moves from in-network to out-of-network status
  - Agencies will issue regulations; industry will be given a reasonable amount of time to comply with any new requirements

CAA Price Transparency and Cost Disclosure Rules

Service Provider Compensation

- Health benefit brokers and consultants must disclose to plan sponsors any direct or indirect compensation received for referral of services

CAA Reporting on Pharmacy Benefits and Drug Costs

As of December 2022 (but potentially earlier), and each June thereafter, group health plan must report data on pharmacy benefits and drug costs, including:

- Plan year, number of plan participants, and each state in which plan or coverage is offered
- Plan's 50 brand prescription drugs most frequently dispensed by pharmacies and total number of paid claims for each such drug
- Plan's 50 most costly prescription drugs
- 50 prescription drugs with greatest increase in plan expenditures over plan year preceding the reported plan year
- Plan's total spending on health care services, broken down by type of cost (e.g., hospital, health care provider)
- Average monthly premium paid
- Impact on premium and OOP costs by rebates, fees and any other amounts paid by drug manufacturers to plan or administrators (presumably, PBMs)

GUIDANCE FORTHCOMING. So, NO ACTION YET PER FAQs Part 49

This requirement was originally scheduled to be effective as of December 2021

No Surprises Act

Initial wave of guidance posted in Federal Register on 7/13/2021

- Comments requested
- Generally effective as of plan year beginning on or after 1/1/2022
- Proposed rule issued to help collect data on the air ambulance provider industry issued on 9/10/2021

Intent of "No Surprises Act" (enacted as part of the CAA, 2021)

- Prohibits participants from receiving surprise balance bills (a/k/a "balance billing"):
  - In certain emergency situations
  - When going to an in-network facility where certain services and procedures are performed by OON providers (e.g., OON anesthesiologists, radiologists, etc.)
  - Out-of-network air ambulances
- The Act establishes
  - What cost-sharing amounts participants can be charged in a surprise medical billing situation
  - The procedure for determining payment to providers from plans and
  - When notice and consent are required

Note: The Act replaces the emergency services provisions of the ACA and prohibits plans from placing certain restrictions on emergency services

No Surprises Act

Plans to Which Requirements Apply

- Grandfathered and Non-Grandfathered Group Health Plans
- Non-federal governmental plans
- Church Plans

Plans Excluded

- Excepted benefits, e.g., most dental/vision/EAPs
- Retiree-only plans
- Health Reimbursement Arrangements (and other account-based plans)
- Short-term limited duration plans
- Additional comments requested by the Agencies

No Surprises Act

Emergency Services

- No preauthorization
- No regard to network status
  - If emergency services provide out-of-network, then coverage limitations cannot be more restrictive than those that apply on an in-network basis

Non-Emergency Services Provided at an In-Network Facility

- Cannot be higher than if such services were provided by an in-network provider, and any cost-sharing obligation must be based on in-network provider rates
- Prohibits OON charges for items or services provided by an OON provider at an in-network facility, unless certain notice and consent is given
- Providers and facilities must provide patients with a plain-language consumer notice explaining that patient **consent** is required to receive care on an OON basis before that provider can bill the patient more than in-network cost-sharing rates

No Surprises Act

Cost-Sharing Provisions

- Cost sharing for emergency services provided OON or cost sharing for non-emergency services provided by OON providers at in-network facilities are generally calculated as if the total amount charged is equal to the "recognized amount" for these services
  - These amounts also must be applied towards any out-of-pocket (OOP) amounts
- "Recognized Amount" defined as:
  - An amount determined by an applicable All-Payer Model Agreement as set out in the Social Security Act
  - If there is no applicable All-Payer Model Agreement, an amount determined by state law; or
  - If neither is applicable, the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (the QPA), which is generally the median of the contracted rates by the Plan for the specific item or service in the geographic area
    - Most self-insured group health plans will utilize QPA unless they have voluntarily opted into state surprise billing laws

No Surprises Act

Cost-Sharing Provisions

- Where neither the All-Payer Model Agreement or state law applies, the balance of the bill to be paid by the plan after the patient cost sharing and any initial payment from the plan is determined between the provider, facility, provider of air ambulance services, and the plan through a 30-day open negotiation period, and if the parties cannot agree on a payment amount the federal independent dispute resolution (IDR) process can be initiated

  - Guidance issued on 9/30/2021 outlines how this process initiates, what is eligible for this process, and how IDR entities should consider factors when determining a payment amount
  - $50 fee for 2022 (paid by each party) plus IDR fee paid by the “non-prevailing” party
  - Coverage decisions involving surprise billing are eligible for the external review portion of the “ERISA” Claims & Appeals process
    - May require an SPD update and even GF plans who are not normally subject to external review must provide external review for this purpose

No Surprises Act

Notice and Consent Procedures

- The specific procedures under the Act may not apply under certain circumstances to post-stabilization services or OON non-emergency services (other than air ambulance services or ancillary services at in-network facility) if the provider or facility provides notice to and receives consent from the participant
- Providers and facilities are required to notify plans when the notice and consent criteria have been satisfied so plans will know whether IFR requirements regarding cost-sharing and payments to plans apply
- Plans also will be required to publicly post a notice describing the prohibitions on surprise billing and who to contact if a violation is suspected
  - This information must be included on all EOBs to which protections apply
- Part 49, FAQ No. 9 highlighted that the Agencies may address the balance billing requirements in more detail in future guidance
  - Until then, a good faith approach is expected
  - A model notice was issued for this purpose: CMS-10780 | CMS

Mental Health Parity CAA Update

Agencies must prepare a compliance program guidance document with specific examples of non-quantitative treatment limitations (NQTLs), which are limits on scope or duration of benefits:

- Prior authorization
- Medical management standards
- Limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether the treatment is experimental or investigative
- Limitations with respect to prescription drug formulary design
- Use of “fail-first” or “step-therapy” protocols

Under existing law, group health plan must demonstrate parity between medical/surgical benefits and mental health/substance use disorder (MH/SUD) benefits through:

- Testing requirements on financial and quantitative treatment limitations
- Ensuring that NQTLs are no more restrictive on MH/SUD benefits than on medical/surgical benefits

Mental Health Parity CAA Update

Consolidated Appropriations Act of 2021

- The CAA re-emphasized the requirement to complete and retain NQTL analysis
- An update in the “statute”
  - No guidance to date so limited information
  - Appears to largely reiterate existing requirements
- Analysis must be ready in the event of audit which could technically be as early as 2/10/2021 (“upon request by HHS or DOL or IRS”)

Mental Health Parity CAA Update

Comparative analyses and the following information must be available upon request:

- The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical/surgical benefits to which each such term applies in each respective benefits classification (Step 1)
- The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical/surgical benefits (Step 2)
- The evidentiary standards used for the factors identified when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical/surgical benefits (Step 3)
- The comparative analysis demonstrating compliance (Step 4)
- 4/2/2021 FAQs
  - At least 9 elements must be provided in report to DOL upon audit (see Appendix for details)

Mental Health Parity CAA Update

- DOL must complete at least 20 reviews per year
- If DOL determines during a review that the employer/plan sponsor did not provide sufficient information, then
  - Plan sponsor has 45 days to correct or show additional information that demonstrates compliance AND
  - If still not in compliance, then 7 days after such determination, the plan sponsor must notify ALL plan participants of non-compliance
- Secretary will submit a report to Congress of its findings
- Secretary will provide additional guidance and regulations within 18 months after the date of enactment

Mental Health Parity CAA Update

Compliance Program Document: Secretary (DOL, IRS, HHS) will prepare a compliance program guidance document

- May take into consideration the attached (2016) https://www.hhs.gov/guidance/document/warning-signs-plan-or-policy-non-quantitative-treatment-limitations-nqtls-require
- ***Will include examples of compliance and violations and will include sufficient detail to fully explain such finding***
- Document will be updated every 2 years
- Examples will be prepared that will help participants, contracting providers, and authorized representatives of the plan comply with NQTLs

Employer-Sponsored Group Health Plans and COVID-19 Vaccination Incentives (Anti-Vaccination Surcharges)

Vaccination or Testing Mandate on Employers

On 9/9/2021, President Biden announced that the U.S. Department of Labor Occupational Safety and Health Administration (OSHA) division is developing an emergency temporary standard (ETS) to require all employers with 100 or more employees to ensure:

- All employees are vaccinated OR
- Any employee who is not vaccinated is tested at least once per week

Many Outstanding Questions Including:

- Will full-time and part-time employees be included? What about remote workers?
- What about employers that are outside of OSHA's jurisdiction?
- Who will pay for the testing? The employer or the government?
  - Complex group health plan issues at play
- How will this interact with HIPAA's wellness rules for employers who are implementing an incentive for vaccinated participants (or penalty for unvaccinated participants)?
- Is the mandate constitutional?

Incentivizing Vaccines

Incentivizing vaccines through the employer-sponsored group health plan is best categorized as a Health Contingent wellness program (i.e., the participant must have an outcome to receive the incentive)

- It's more than just participatory

A Health Contingent wellness program is broken down further into 2 types: activity only or outcomes based

- On 10/4/2021, the Agencies confirmed in FAQs Part 50 that a vaccine incentive/unvaccinated surcharge is Health Contingent Activity-Only wellness program

Incentivizing Vaccines

A Health Contingent Activity Only program must comply with the following so that HIPAA is not violated:

- Participants must be given the opportunity to qualify at least once per calendar year
- The incentive, *together with the reward for other health contingent wellness programs*, cannot exceed 30% of the cost of elected coverage (or 50% for tobacco)
- Program must be reasonably designed to promote health or prevent disease and cannot be overly burdensome or a subterfuge for discriminating based on a health factor
- Must be offered to all similarly situated individuals and a reasonable alternative standard must be available to those who cannot complete
  - If activity-only, the wellness program would only need to offer the reasonable alternative IF it is unreasonably difficult due to a medical condition or medically inadvisable to satisfy the otherwise applicable standard (to be vaccinated)
- Notice of availability must be provided
  - Notice must include the availability of a reasonable alternative standard to qualify for the reward and recommendations of an individual's personal physician will be accommodated

Incentivizing Vaccines

Employer Shared Responsibility and Incentives under Wellness Program

- Surcharge/incentive to a medical plan premium/premium equivalent will work against the cost of coverage for ESR purposes
  - Might increase risk of an Internal Revenue Code section 4980H(b) penalty
  - Exception if surcharge/incentive is related to non-tobacco use
- For example, if employer's cost of employee-only coverage is $95 per month and surcharge for those who are unvaccinated is $200 per month then, employee's cost of coverage is $295 for purposes of determining affordability under ESR (IRS Form 1095-C)
- If coverage is not affordable and full-time employee enrolls in government exchange (Health Insurance Marketplace), a penalty of $334 per month could apply
  - Penalty cannot apply if employee remains enrolled in employer's coverage
  - Complications with mid-year enrollment (but at annual enrollment could be a concern)
  - American Rescue Plan expanded who can receive a subsidy in the government exchange to include those who earn more than 400% of the FPL (just for 2021 and 2022)
- Confirmed by Agency FAQs Part 50, No. 5

Other Penalties

Agencies confirmed that a health plan cannot condition eligibility for benefits or coverage for otherwise covered items or services to treat COVID-19 on participants on being vaccinated

- Discrimination based on a health factor – violation of HIPAA nondiscrimination rules
- Only exception is premium discounts or rebates, or modifications of otherwise applicable cost-sharing mechanisms, that comply with the wellness program requirements
  - Cannot deny eligibility or coverage based on vaccination status
- Confirmed by Agency FAQs Part 50, No. 4

Checklist of Recent Changes

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	▪ COVID-19 testing at no cost (in- and out-of-network), includes serological related tests during PHE ▪ If HSA/HDHP, COVID-19 testing paid before deductible	Required	FFCRA CARES Act FAQs
	COVID-19 treatment paid before deductible in HSA/HDHP	Optional	IRS Notices 2020–15 & 2020–29
	Vaccine. Coverage of COVID-19 preventive care items and services, including vaccines and immunizations at no cost (within 15 business days of recommendation) [only non-GF health plans technically] & OON during PHE	Required	CARES Act and FAQs
	HSA/HDHP to cover telehealth and other remote care services without a deductible or deductible below the minimum ($1,400 for individual and $2,800 for family in 2020 & 2021); temporary until **12/31/2021** *Monitor for guidance to expand or make permanent*	Optional	CARES Act and FAQs
	Student Loan Changes to allow for tax free reimbursement of student loans before **1/1/2026**	Optional	CARES Act & CAA, 2021

FAQs means DOL, IRS, HHS FAQs Part 42, 43, and/or 44 unless otherwise noted

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Over-the-counter drugs and menstrual products may be reimbursed by health FSA, HSA, or HRA for expenses paid on or after 1/1/2020	Optional	CARES Act
	COVID-19 personal PPE under a health FSA, HSA, or HRA for expenses paid after 1/1/2020	Optional	**IRS Announcement 2021-7**
	Deadlines Extended for COBRA, HIPAA special enrollment, and ERISA claims and appeals—employee communication should be considered with legal counsel **See EBSA Notice 2021-01 with modified guidance (lesser of 1 year or end of Outbreak Period)—individualized**	Required	EBSA Notices 2020-01 and federal register and **2021-01 IRS Notice 2021-58**
	Additional health coverage midyear changes allowed in 2020 **and 2021** for medical, dental, or vision coverage: ▪ Make a new health election on a prospective basis, if the employee initially declined to elect employer's health coverage ▪ Revoke an existing health coverage election & make a new election to enroll in different health coverage sponsored by same employer (benefit options such as HMO, PPO, HDHP) or coverage tier (single, family, etc.) ▪ Revoke an existing health election on a prospective basis, employee attests to enrollment in other coverage	Optional	IRS Notice 2020–29 **CAA of 2021 & IRS Notice 2021-15**

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Health Care FSA midyear changes permitted on a **prospective** basis for 2020 **and 2021:** ▪ Revoke an election ▪ Make a new election ▪ Decrease or increase an existing election	Optional	IRS Notice 2020–29 **CAA, 2021/IRS Notice 2021-15**
	Dependent Care FSA midyear changes permitted on a **prospective** basis for 2020 **and 2021:** ▪ Revoke an election ▪ Make a new election ▪ Decrease or increase an existing election	Optional	IRS Notice 2020–29 **CAA, 2021/IRS Notice 2021-15**
	Health Care FSA. For unused amounts remaining as of end of a grace period or plan year ending in 2020 (e.g., a non-CY PY), a cafeteria plan may permit employees to apply those unused amounts to pay or reimburse medical care expenses incurred through 12/31/2020	Optional	IRS Notice 2020–29
	Dependent Care FSA. For unused amounts remaining as of end of a grace period or plan year ending in 2020 (e.g., a non-CY PY), a cafeteria plan may permit employees to apply those unused amounts to pay or reimburse dependent care expenses incurred through 12/31/2020	Optional	IRS Notice 2020–29
	Health Care FSA Carryover amount increased to $550 starting in 2020	Optional	IRS Notice 2020–33

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Carryover. Employers may amend Health Care FSA and/or Dependent Care FSA to allow employees to carry over unused amounts in their DC and HC FSAs from 2020 into the **plan year ending in 2021 and from 2021 into 2022**	Optional	CAA, 2021 IRS Notice 2021-15
	Grace Period. Employers may amend Health Care FSA and/or Dependent Care FSA to allow employees to extend grace periods through the end of 2021 **and again extend in 2022**	Optional	CAA, 2021 IRS Notice 2021-15
	Dependent Care FSA. Extend maximum age of eligible dependent from age 13 to age 14 for 2021 if dependent aged out in 2020 and employee was a DC FSA participant in 2020	Optional	CAA, 2021 IRS Notice 2021-15
	Spend Down Provision. Employer may amend Health Care FSA, like a Dependent Care FSA, to allow employees who terminate participation to continue to incur expenses and claim reimbursement during plan year	Optional	CAA, 2021 IRS Notice 2021-15
	Dependent Care FSA. Increase in reimbursement exclusion limit to $10,500 or $5,250 married filing separately	Optional	American Rescue Plan of 2021 IRS Notice 2021-26

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Updated Model COBRA Notices ▪ Model COBRA notices updated to consider interaction with Medicare ▪ *Additional COBRA model notices and FAQs for premium assistance (subsidies) issued on 4/7/2021*	Optional, but **strongly** recommended	Model Notices and FAQs issued on 5/1/2020
	COBRA subsidy. American Rescue Plan implements a subsidy of 100% for involuntary terminations/reduction in hours from 4/1/2021–9/30/2021; *many details apply.* Notice and related administrative requirements will impact TPAs and payroll.	Required	American Rescue Plan of 2021; Model Notices and FAQs issued on 4/7/2021; IRS Notices 2021-31, 2021-46; 2021-58
	Government Marketplace. Increase in subsidies for those earning more than 400% of the FPL should not affect affordability penalty, **but employers *should confirm***. If employer is using affordability safe harbor for all pay bands, then no issue (e.g., FPL, W-2, rate of pay).	Required	American Rescue Plan of 2021

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	HHS 2021 Notice of Benefit & Payment Parameters Final Rule ▪ Rx Coupons may or may not apply towards the ACA OOP maximum ▪ Coupons should never apply towards deductible under an HSA compatible HDHP ▪ State law?	Design Option for non-HDHPs	2021 HHS Final Rule
	Impact of Section 1557 2020 Final Rule & *Bostock v. Clayton County* HHS issued a notice of interpretation and enforcement that confirms that Section 1557 prohibits discrimination on the basis of sexual orientation and gender identity; this is consistent with the original 1557 rules and Bostock and reverses Trump administration final regulations. However, it does not appear that other requirements (e.g., notices) have been re-implemented under 1557 or the concept of a covered entity.	Required/Continue to Monitor	Section 1557 2020 Final Rule and U.S. Supreme Court Case and 5/10/2021 HHS Notice of Interpretation and Enforcement

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Mental Health Parity and Addiction Equity Act ▪ Not new: Complete QTL testing and work with TPAs on NQTL matters ▪ Monitor additional guidance as required by CAA of 2021 ▪ TPA contract considerations	Required	MHPAEA CAA, 2021 FAQs issued 4/2/2021
	Affordable Care Act and Transparency ▪ Regulations under Trump Administration (ACA requirement) ▪ Requires group health plans to disclose cost-sharing information upon request to a participant, including an estimate of the individual's cost-sharing liability for covered items and services ▪ Not applicable to grandfathered plans or "retiree-**only**" plans ▪ Details apply—layered effective dates for different requirements 2022, 2023, and 2024 ▪ TPA contract considerations	Required	ACA and recent regulations; FAQ Part 49 Delayed Implementation
	CAA, 2021 and Transparency ▪ CAA, 2021 (e.g., advanced EOB, continuity of care, accuracy of provider directory updates, removal of gag clauses) ▪ TPA contract considerations	Required	CAA, 2021, FAQ Part 49 Significant re: Implementation Deadlines

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Surprise Medical Billing including air ambulance ▪ Generally effective for PY beginning on or after 1/1/2022 ▪ TPA contract considerations	Required	CAA, 2021; regulations issued 7/1/2021, 9/10/2021, and 9/30/2021
	Reporting on pharmacy and Rx costs ▪ Regulations to be issued (stay tuned) ▪ TPA contract considerations	Required	CAA, 2021; on hold per FAQ Part 49
	Awaiting finalization of regulations on wellness plans	Required	EEOC proposed regulations under review by Biden Administration
	Individual state mandates and related filings: ▪ Massachusetts ▪ District of Columbia ▪ New Jersey ▪ California ▪ Rhode Island ▪ Vermont	Required	State Mandates

Documentation Considerations

Check Box √	Description
	Plan Amendments May Be Necessary, for example: ▪ Mandatory and permissive changes under the law, e.g., COVID-19 testing at no cost, COVID-19 treatment before deductible ▪ Changes in eligibility as a result of continued coverage during an unpaid leave or furlough ▪ Cafeteria plan midyear changes and spending account changes require an amendment—deadline is 12/31/2021 or later for later changes, see IRS Notice 2021-15
	SPD Updates/SMM OR Related Communication May Be Necessary ▪ Mandatory and permissive changes under the law, e.g., COVID-19 testing at no cost, COVID-19 treatment before deductible ▪ Changes in eligibility as a result of continued coverage during an unpaid leave or furlough ▪ Cafeteria plan midyear changes and spending account changes ▪ Delays in deadlines for COBRA, HIPAA special enrollment and ERISA claims and appeals should be communicated to employees/retirees/participants pursuant to employer's role as fiduciary—additional communication likely required as a result of EBSA 2021-01
	SBC: Relief given but update if necessary and when possible (See FAQs)

Questions?

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