ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

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2021: A TUMULTUOUS YEAR IN REVIEW

As we wind-down 2021 with an eye toward 2022 compliance we are faced with the most significant changes to employer health benefits since the Affordable Care Act.

In addition to ongoing COVID relief provisions we are faced with new "surprise billing" and transparency requirements that will begin to kick-in as plans renew for the 2022 year.

Below we provide an overview of the most significant changes we face from 2021. Reference is made to our prior articles for a more complete discussion on most issues.

Supreme Court Affordable Care Act Decision: In June, the Supreme Court ruled on a case (again) challenging the Constitutionality of the Affordable Care Act (ACA). The Court quickly dispensed with the decision, holding that the plaintiffs did not have standing to challenge the law. Because the opinion turned on the threshold issue of standing, the Court did not address the merits of the challenge.

Thus, we may never know whether stripped of its tax provision, the "penalty-less coverage requirement" rises to the level of an unconstitutional "mandate". So it's business as usual with regard to ACA requirements including ACA reporting and the so-called employer "pay or play" requirement.

Outbreak Period Guidance: In 2020 plans were faced with the COVID Outbreak period requirement and a 1 year "tolling" of certain time deadlines. Agency guidance from February 2021, EBSA Disaster Notice 2021-01, clarified the application of the statutory 1-year limitation.

Notice 2021-01 provides that 1-year limit does not apply to the Outbreak Period itself, but rather applies to each individual's specific time period. Thus, individuals and plans with timeframes that are subject to the "tolling period" relief will have the applicable periods disregarded until the earlier of (i) 1 year from the date they were first eligible for relief or (ii) 60 days after the announced end of the National Emergency (the end of the Outbreak Period). In no case will a disregarded period exceed 1 year.

Once the Outbreak Period ends for a particular action, plans may resume counting when determining the due date for that action. The IRS provided further clarification with regard to certain tolled COBRA premium requirements in Notice 2021-58.

COVID-19 Testing & Vaccination Coverage: The Centers for Medicare & Medicaid Services (CMS) issued new FAQs in early 2021 covering COVID-19 testing and vaccinations. Plans may not impose medical screening criteria to deny or impose cost sharing for individual diagnostic testing on asymptomatic individuals. Plans are required to cover testing provided through governmental administered testing sites as well as point-of-care tests, but are not required to cover testing for public health surveillance or employment purposes.

Plans are also required to cover, without cost sharing, all approved vaccines within 15 business days after their recommendation. This includes covering the vaccine administration fee, even where the government or another party pays for the vaccine itself.

Agencies will take no action concerning the 60-day advance notice requirement for changes to a summary of benefits and coverage (SBC) relating to the vaccine as long as notice is provided as soon as reasonably practicable. Employers may offer vaccines through an employee assistance program (EAP) and it will not be considered to provide "significant benefits in the nature of medical care," allowing the EAP to qualify as an excepted benefit under the ACA. Excepted benefit status also exists for vaccines provided through onsite clinics.

Health Plan COVID-19 Vaccine Incentives: The primary benefits concern in offering COVID-19 vaccination incentives (or surcharge) through an employer health plan arises under the HIPAA nondiscrimination rules for wellness programs. If the wellness program is considered to be health contingent, then limits on the "reward" and other requirements apply.

Health contingent wellness programs are those that provide rewards in exchange for either (i) achieving a specific heath outcome ("outcome-based") or (ii) completing a health-related activity ("activity based"). Agency guidance has confirmed that a health plan reward/ surcharge based on vaccination status will be subject to the HIPAA requirements. See Agency Faqs 50.

Requirements for a HIPAA non-discriminatory health contingent program include:

- The total reward cannot exceed 30% of the total costs of single coverage (or family coverage if dependents are allowed to participate)
- Participants must be permitted to re-qualify for the reward at least once per year
- The program must be available to all similarly situated individuals
- Participants must receive notice that a reasonable alternative will be provided (e.g., if they cannot achieve the standard due to a health condition); and
- The program must be reasonably designed to promote health or prevent disease

Additional vaccine incentive guidance was published by the EEOC in May 2021, which clarified that providing incentives to employees for verifying that the employee or the employee's family received a vaccination from a third party that has not been engaged by the employer to provide the vaccine does not constitute a disability related inquiry or a request for the employee's genetic information that would otherwise be subject to the the American With Disabilities Act (ADA) and Genetic Information Nondiscrimination Act (GINA).

The guidance also covers incentives for employees and employee's families receiving COVID-19 vaccinations from an employer or employer's agent. For employees, a vaccine screening questionnaire is a disability related inquiry triggering the ADA. However, the questionnaire for employees does not trigger GINA since the medical screening questions do not inquire about genetic information of the employee.

Vaccination incentives can be offered, but under the guidance, incentives, including both rewards and penalties, cannot be "so substantial as to be coercive." The guidance does not provide parameters for what size of an incentive would be so substantial as to be coercive.

For employee's families receiving vaccines from an employer or employer's agent, vaccine screening questions do seek genetic information in the form of family medical history of the employee, and thus incentives for vaccination of the employee's family members are prohibited under GINA. Vaccinations may still be provided to family members without incentives if certain conditions are met.

HIPPA – HITECH Cybersecurity Amendment: H.R. 7898 was signed into law on January 5, 2021 and amends the HITECH Act. This amendment directs the Office for Civil Rights to consider "recognized security practices" implemented by covered entities to prevent cyber security threats when accessing fines for violations, conducting audits, and determining remedies for potential violations during settlement agreements.

Recognized security practices must be adequately demonstrated by the covered entity or business association and have been in place for at least the previous 12 months. Covered entities should ensure that a HIPAA Security Risk Assessment has been recently performed and documented, and they must determine that adopted recognized security practices are consistent with the HIPAA Security Rules.

AMERICAN RESCUE PLAN ACT OF 2021 (ARPA)

Temporary COBRA subsidy: ARPA provided a 100% COBRA premium assistance subsidy for the period April 1, 2021 to September 30, 2021. The subsidy applied to qualified beneficiaries, including qualified beneficiary spouse and dependents (referred to as "assistance eligible individuals" or AEIs), whose original COBRA qualifying event was an involuntary termination of employment or a reduction in hours of employment.

To be eligible for the COBRA subsidy, an AEI could not be eligible for other group health plan coverage or Medicare. AEIs whose qualifying event occurred prior to April and that had yet to elect were offered a 2nd election opportunity if their COBRA period extended into the subsidy period ending September 30, 2021.

Generally, employers with plans subject to federal COBRA, whether fully insured or self-funded, advanced the subsidy and will recoup the advanced premium through tax credits against the employer's Medicare payroll tax obligations, on Form 941 or Form 7200. Retaining AEI attestation forms to verify an ARPA eligible event (involuntary termination of employment or reduction in hours) and that there is no other disqualifying coverage is a best practice for employers in the case of an audit.

Temporary Increase for DCAPs: For the 2021 taxable year, ARPA temporarily raised the amount that an employee can exclude from gross income for DCAP

benefits, increasing from $5,000 to $10,500. This increase is set to expire absent further Congressional action.

Thus, ARPA does not extend to 2022. At present, any unused DCFSA amount from 2021 that remains available for use in 2022 will be subject to the prior $5,000 limit. Any expenses over the $5,000 limit become taxable in 2022. In Notice 2021-26, the IRS provided guidance as to how the ARPA increase integrated with the other DCAP carryover provisions allowed under CAA 2021 (see below).

CAA 2021 Temporary Relief for Cafeteria Plans, Health FSAs and DCAPs The 2021 Consolidated Appropriations Act (CAA) allows employers to amend cafeteria plans for plan years ending in 2021 to allow health plan election changes without a corresponding change in status event Health FSAs and DCAPs to carry over unused benefits from (i) a plan year ending in 2020 to a plan year ending in 2021, and (ii) a plan year ending in 2021 to a plan year ending in 2022. Alternatively, the CAA allows a health FSA or DCAP to extend its 2 ½ month grace period for a plan year ending in 2020 or 2021 to 12 months after the end of the plan year with respect to unused benefits.

The CAA also temporarily expanded eligible DCAP dependents to age 13 for unused DCAP grace period amounts from the 2020 plan year or carryover funds carried over into the 2021 plan year. The IRS provided guidance with regard to these temporary provisions in IRS Notice 2021-15.

CONSOLIDATED APPROPRIATIONS ACT OF 2021

No Surprises Act (NSA) – Surprise Billing: These provisions dramatically change the way that certain emergency and additional (e.g., ancillary) health benefits are administered and requires changes beginning with plan years on and after January 1, 2022. It is applicable to all plan sponsors, including grandfathered and non-grandfathered health plans, and TPAs.

However, it does not apply to excepted benefits (e.g., most health FSAs) or retiree health plans.

Under the NSA, plan participants' and beneficiaries' financial obligations are limited to in-network (INN) cost sharing (deductibles, co-payments, and co-insurance) for services provided by an out-of-network (OON) provider in three instances:

(i) Emergency services at a hospital's Emergency Department (ED), including a hospital outpatient department, or at a freestanding ED;

(ii) "Ancillary" services that are provided by an OON provider at an INN facility, including services provided by an OON provider because there is no INN provider who can furnish the service at the facility;

(iii) Non-emergency services performed by an OON provider at an INN facility, unless the OON provider gives the patient notice and the patient consents to using the OON provider (consent is unavailable for emergency or ancillary services).

For emergency services, if a plan covers any benefits for services in an ED of a hospital or emergency services in a freestanding ED: (1) plans cannot impose prior authorization requirements on emergency services (whether INN or OON); (2) plans must cover emergency services even if the provider or facility is OON; (3) if the services are provided by an OON provider or facility, the plan cannot impose any requirement for prior authorization or any limitation on coverage that is more restrictive than the requirements that apply to in-network emergency services; and (4) plans must cover emergency services without regard to any other term of condition of coverage, other than an exclusion or coordination of benefits or a permitted affiliation or waiting period

Additionally, plans must count participant cost-sharing for these OON services in the same manner as INN cost-sharing (e.g., counting the cost-sharing against any in-network deductible or out-of-pocket amount). In applying the plan's INN cost-sharing provisions to these OON services, the "recognized amount" is generally the qualifying payment amount, as defined by the NSA or the billed charge if lower.

Finally, providers may not balance bill patients for the amount exceeding INN cost sharing for the OON services. Health plans are required to make initial payment to the OON provider or issue initial denial of claims within 30 days.

The Act also creates an Independent Dispute Resolution (IDR) process for disputes arising between providers and plans. The IDR arbitration process applies where no existing state law providing equal or greater protection to patients is applicable.

The IDR process includes a 30-day cooling-off period after the initial payment/denial is received to allow the parties to negotiate. If no agreement is reached, either party may submit the dispute to the IDR process. IDR is a "baseball style" arbitration, where each side submits a payment offer and the arbitrator chooses between the two.

In general, the IDR arbitrator can consider any factors submitted by either party in making its decision, with some limited exceptions. For example, the arbitrator may not consider usual and customary charges, billed charges, or the governmental rate (e.g., Medicare). The losing side pays the costs of arbitration. Similar payment and dispute resolution rules apply to air ambulance services, but not ground ambulance.

No Surprises Act - Disclosure and Transparency Rules: A number of disclosure and transparency provisions are included in the NSA, imposing new requirements on health plans. The tri-agencies (CMS/DOL/Treasury) issued the Transparency in Coverage (TiC) Final Rules setting forth requirements for group health plans and health insurers under the ACA.

The final rule applies to group health plans and group health insurance issuers who are otherwise subject to the ACA health insurance reforms. The final rule is not applicable to HRAs (Integrated HRA, ICHRA and QSEHRA) or grandfathered plans. On August 20, 2021, the Agencies jointly released FAQs providing clarification for the various requirements of the TiC and the NSA, including extending certain effective dates. The new disclosure and transparency requirements include:

- Continuity of Care – When a provider leaves a plan's network, the plan must provide participant notice of INN network provider's termination. The plan must then allow coverage for certain services by the same provider as if the provider were still INN for a continuation period of up to 90 days. This continuation coverage applies where an individual is undergoing a course of treatment for serious and complex conditions, institutional or inpatient care, scheduled non-elective surgery, pregnancy, or care for a terminal illness. (Effective for Plan Years on/ after 01/01/2022).

- Price Comparison Tool – Maintain price comparison tools available online and over the phone. (Effective for Plan Years on/after 01/01/2023 for most common expenses, and 01/01/2024 for all covered expenses).

- Advanced Explanation of Benefits (EOB) – Provide an advanced explanation of benefits before scheduled care, including information such as the estimates of cost-sharing and the amount the plan will pay for the service, how much the patient has already incurred toward financial limitations in the plan, and whether the provider is in-network or OON. (Originally effective 01/01/2022, but deferred enforcement until regulations implementing requirements are issued).

- Provider Fee Disclosure and Notice – Providers must provide notice of scheduled services/treatments and good faith estimates of costs to plans/ insurers. (Originally effective 01/01/2022, but deferred enforcement until regulations implementing requirements are adopted).

- MHPAEA Parity Analysis – *discussed in detail below.*

- Compensation Disclosure – *discussed in detail below.*

Other disclosure and transparency requirements include deductible disclosure requirements for identification cards, provider directory requirements, a prohibition on gag clauses in agreements between plans and a third party, prescription drug cost reporting, machine readable disclosure of rates.

MHPAEA Parity Analysis: The Mental Health Parity and Addiction Equality Act (MHPAEA) requires parity between certain aspects of medical/surgical (Med/Surg) benefits and mental health/ substance use disorder (MH/SUD) benefits. Generally, nonquantitative treatment limitations (NQTLs) cannot apply any more stringently to MH/SUD benefits than they apply to Med/Surg benefits. NQTLs are non-numerical/ non-dollar limits on the duration or scope of benefits, such as requiring medical necessity and prior authorization. Parity must not only be on the face of the plan but also in operation.

The CAA requires the performance *and documentation* of a comparative analysis of the plan's or policy's design and application of NQTLs showing MHPAEA compliance. The five-part NQTL analysis is required to include:

- Identification of the NQTLs

- Factors considered in the design of the NQTL

- Evidentiary standards and sources used to develop the factors

- A comparative analysis of the NQTLs as written and in operation
- Findings and conclusions establishing compliance with the MHPAEA requirements

The Agencies are required to provide further guidance on MHPAEA compliance through a "compliance program guidance document" issued within 18 months of enactment. With the regulatory guidance is still in the works, the DOL has issued several useful tools with regard to NQTLs, including a self-compliance tool and a list of MHPAEA NQTL warning signs.

Agencies, state regulators, and participants can all request this written analysis, and the written analysis must be available, upon request, within 45 days after enactment of the CAA on February 10, 2021. If an agency finds the plan is non-compliant then there is a 45 day "cure period." If not cured in that period, the agency will notify all enrolled in the plan of the plan's noncompliance.

The goal of this requirement appears to be one of better overall compliance. Violations of MHPAEA under ERISA are limited to what is known as "equitable relief." That can include requiring a plan to reprocess claims if they were improperly denied or not fully reimbursed because of a noncompliant NQTL.

There is currently, however, no civil monetary penalty for MHPAEA violations under ERISA. Pending legislation would amend ERISA to impose civil penalties for MHPAEA noncompliance.

Compensation Disclosure Requirement: Effective for contracts or arrangements entered into (or extended) after December 27, 2021, brokers and consultants will be required under an amendment to §408(b)(2) of ERISA to make disclosures if they receive $1,000 or more in total annual direct and indirect compensation.

This requirement covers group health plans, including excepted benefits like stand-alone dental and vision, Health FSAs, certain EAPs, on-site clinics (except those limited to rendering first aid to employees during working hours), as well as HRAs. The categories of required disclosures mirror regulatory requirements applicable to retirement plans since 2012.

Direct compensation is compensation from the plan itself. Indirect compensation is generally amounts received from anyone other than the covered plan, the plan sponsor, the service provider, or an affiliate of the service provider.

If the only compensation that a service provider receives derives directly from the employer, then disclosure is not required. Thus, careful analysis should be done as to whether plan assets are involved in the compensation amount.

Disclosures must be made to the responsible plan fiduciary "reasonably in advance' of the date of entering into, extending, or renewing any contractor arrangement. If disclosures are not provided, plan fiduciaries must take a series of actions including ultimately notifying DOL and terminating the service provider in order to avoid a prohibited transaction under ERISA section 406.

Updated Health Plan COLA Provisions

Many of the 2021 benefit amounts have been updated for cost of living adjustment (COLA) changes. We include some of the more frequently inquired about amounts below. ■

BENEFIT	2021	2022
HSA contribution max (including employee and employer contributions)	$3,600 ($7,200 family) (Rev. Proc. 2020-32)	$3,650 ($7,300 family) (Rev. Proc. 2021-25)
HSA additional catch-up contributions	$1,000 (this is not indexed)	Same
HDHP annual deductible minimum	$1,400 ($2,800 family) (Rev. Proc. 2020-32)	Same (Rev. Proc. 2021-25)
Limit on HDHP OOP expenses	$7,000 ($14,000 family) (Rev. Proc. 2020-32)	$7,050 ($14,100 family) (Rev. Proc. 2021-25)
ACA limit on OOP expenses	$8,550 ($17,100 family)	$8,700 ($17,400 family)
Health FSA salary reduction max	$2,750	2850
Health FSA carryover max	$550	570
Limit on amounts newly available under an Excepted Benefit HRA	$1,800	Same (Rev. Proc. 2021-25)
QSEHRA max reimbursement	$5,300 ($10,700 family)	5450 (11,050)
Transit and parking benefits	$270 (monthly)	280
401(k) employee elective deferral max	$19,500 (Catch-up contributions $6,500)	$20,500 (Catch-up contributions $6,500)
Highly compensated employee	$130,000 (applies for 2022 plan year under look-back rule)	$135,000 (applies for 2023 plan year under look-back rule)
Key employee	$185,000	$200,000