MY BENEFIT ADVISOR

2023: Second Quarter

Compliance Digest

Compliance Bulletins Released April to June

2023 Compliance Bulletins: Second Quarter

April

May

June

July

2023 State Bulletins

Minnesota

New Mexico

Oklahoma

Texas

Washington

Guidance Issued On Emergency Period Expiration

Issued date: 04/14/23

This Compliance Bulletin contains guidance released in FAQ 58; however, President Joe Biden subsequently signed a House Bill on April 10, 2023 immediately ending the National Emergency, which may change certain dates referenced below. It is possible that FAQ 58 will be updated to reflect new dates. The signed Bill did not change the end of the Public Health Emergency, which remains May 11, 2023.

On March 29, 2023, the Departments of Labor, the Treasury, and Health and Human Services (collectively, "the Departments") released FAQ 58, answering certain frequently asked questions regarding the announced end of the National Emergency and the Public Health Emergency ("PHE") on May 11, 2023.

Diagnostic Tests

During the PHE, plans and issuers are required to cover COVID-19 diagnostic tests without any cost sharing, whether in-network or out-of-network. The Departments indicated that, although the plan or issuer may exclude or may require cost sharing of COVID-19 diagnostic tests following the end of the PHE, including over-the-counter ("OTC") testing, they encourage plans to continue to cover COVID-19 testing.

Advance Notice

Plans or issuers that make material modifications to any of the plan or coverage terms that affect the most recently issued Summary of Benefits and Coverage ("SBC") outside of a renewal must provide 60 days advanced notice. However, to the extent the changes are only with respect to cost-sharing and coverage for diagnosis and treatment of COVID-19, or for telehealth or other remote care services in connection with the end of the PHE, the Departments will consider the plan or issuer's notice requirements satisfied if it:

- Previously notified the participant, beneficiary, or enrollee of the general duration of the additional benefits coverage or reduced cost sharing (such as, that the increased coverage applies only during the PHE); or

- Notifies the participant, beneficiary, or enrollee of the general duration of the additional benefits coverage or reduced cost sharing within a reasonable timeframe in advance of the reversal of the changes.

However, notices that were issued regarding coverage during previous plan years will not meet the notice relief described above.

It should be noted that for plans that utilize the standard SBC template, changes to COVID-19 coverage will not materially affect the disclosure and would not require the advanced notice. It is unclear whether these changes would be considered "material."

Although the FAQs did not address this issue, under ERISA, for health plans, a summary of material reduction should be distributed automatically to participants within 60 days of adoption of the material reduction in services or benefits or at regular intervals of not more than 90 days. Although somewhat of a gray area, this should mean that employees hear about the change at least 60 days in advance. It's unclear whether these changes would be considered "material." Regardless, it is recommended to provide advance notice.

A sample employee notice could be:

> Please be advised that in connection with the federal government's announced end of the Public Health Emergency, the **[HEALTH PLAN NAME]** will **[no longer cover or cover subject to regular cost-sharing]** COVID-19 testing (both over-the-counter and in-person). This change will take effect May 12, 2023. All claims incurred before then will be covered in accordance with the requirements of the Public Health Emergency and any relevant federal guidance. Should you have any questions, please contact **[NAME OF CONTACT]** at **[CONTACT INFORMATION]**.

HDHP Coverage Before Minimum Deductible

Normally, for individuals to make or receive health savings account ("HSA") contributions, with limited exceptions, high deductible health plans ("HDHPs") cannot offer any coverage to participants before they satisfy a minimum statutory deductible. While the IRS previously provided guidance that plans will not fail to be considered HDHPs because they cover COVID-19 testing and treatment before the deductible, that guidance was due to the PHE. The FAQs state that the same relief will remain in effect following the PHE until the IRS and Treasury release additional guidance, which will not require HDHPs to make any mid-plan year changes.

Outbreak Period

Certain time periods and deadlines for HIPAA special enrollments, COBRA continuation, and plan claims and appeals must be extended until the earlier of: 1) a period of one year or 2) the end of the Outbreak Period. The FAQs provide some examples illustrating the application of the end of the Outbreak Period (assuming a July 10, 2023 date), as summarized below. It should be noted that, as a result of President Biden's signed Bill, the Outbreak Period may end earlier than July 10, 2023.

Example 1: Electing COBRA

Facts: Individual A works for Employer X and participates in Employer X's group health plan. Individual A experiences a qualifying event for COBRA purposes and loses coverage on April 1, 2023. Individual A is eligible to elect COBRA

coverage under Employer X's plan and is provided a COBRA election notice on May 1, 2023. What is the deadline for Individual A to elect COBRA?

Conclusion: The last day of Individual A's COBRA election period is 60 days after July 10, 2023 (the end of the Outbreak Period), which is September 8, 2023.

Example 2: Paying COBRA Premiums

Facts: Individual B participates in Employer Y's group health plan. Individual B has a qualifying event and receives a COBRA election notice on October 1, 2022. Individual B elects COBRA continuation coverage on October 15, 2022, retroactive to October 1, 2022. When must Individual B make the initial COBRA premium payment and subsequent monthly COBRA premium payments?

Conclusion: Individual B has until 45 days after July 10, 2023 (the end of the Outbreak Period), which is August 24, 2023, to make the initial COBRA premium payment. The initial COBRA premium payment would include the monthly premium payments for October 2022 through July 2023. The premium payment for August 2023 must be paid by August 30, 2023 (the last day of the 30-day grace period for the August 2023 premium payment). Subsequent monthly COBRA premium payments would be due the first of each month, subject to a 30-day grace period.

Example 3: Special Enrollment Period

Facts: Individual C works for Employer Z. Individual C is eligible for Employer Z's group health plan, but previously declined participation. On April 1, 2023, Individual C gave birth and would like to enroll herself and the child in Employer Z's plan. However, open enrollment does not begin until November 15, 2023. When may Individual C exercise her special enrollment rights?

Conclusion: Individual C and her child qualify for special enrollment in Employer Z's plan as early as the date of the child's birth, April 1, 2023. Individual C may exercise her special enrollment rights for herself and her child until 30 days after July 10, 2023 (the end of the Outbreak Period), which is August 9, 2023, as long as she pays the premiums for the period of coverage after the birth.

Employer Action

Employers should:

- Discuss benefit plan design changes with carriers and TPAs as they relate to the coverage for COVID-19 testing and treatment.
- Consider providing advance notice of the change to plan participants.
- Reach out to COBRA TPAs regarding sending out the notices.
- Await further guidance on the end date of the Outbreak Period.
- Be prepared for deadlines to begin to run earlier than expected.

ACA Preventive Care Court Ruling And FAQ

Issued date: 04/26/23

On April 13, 2023, the Departments of Labor, Health and Human Services and the Treasury (collectively, "the Departments") issued FAQ Part 59, providing guidance as it relates to the recent decision in Braidwood Management Inc. v. Becerra. In this case, a district federal court in Texas ruled that many of the ACA's preventive care mandates cannot be enforced nationwide.

Background

Under the ACA, non-grandfathered group health plans must provide coverage for in-network preventive items and services and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services. Specifically,

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC");
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- With respect to women, preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

Summary of the Case

Plaintiffs are six individuals and two businesses who challenge the legality of the preventive care mandates as violative of the Constitution's Appointments Clause and the Religious Freedom Restoration Act ("RFRA"), specifically as it relates to coverage for PrEP drugs (medication for HIV prevention), contraception, the HPV vaccine, and the screenings and behavioral counseling for STDs and drug use.

Among other things, the court in Braidwood ruled against the Departments and held that all agency action taken to implement or enforce the preventive care coverage requirements by the USPSTF (the "A" and "B" recommendations) on or after March 23, 2010, is unlawful and unenforceable nationwide. With respect to the RFRA claims, the court ruled in favor of the plaintiffs enjoining the Department from enforcing coverage as it relates to PrEP with respect to these plaintiffs. The court declined to strike down ACA mandates that provide coverage for contraception, HPV vaccine, and screenings related to STDs and drug use.

While the Department of Justice has filed an appeal and requested a stay of enforcement, the FAQs released provide initial guidance on the impact of the decision.

Effect on Plans

The decision merely enjoins the Departments from enforcing the preventive services requirements that were given an "A" or "B" rating by the USPTF on or after March 23, 2010. Importantly, the requirements to cover contraceptive services, preventive care and screenings, breastfeeding services and supplies, cervical cancer screening, and pediatric preventive care recommended by HRSA, in addition to immunizations recommended by ACIP, were not impacted by the decision. As such, non-grandfathered plans must continue to cover those services without member cost sharing.

While plans are not required to cover more recent "A" or "B" rated recommendations from the USPTF, the Departments strongly encourage plans to continue to do so without cost-sharing. In addition, the court's decision does not affect the application of state laws that may require fully insured plans to continue to cover such services.

However, if a plan chooses to eliminate the coverage or apply cost-sharing, it may require certain notices to participants. Any mid-year change to benefits that affects the content of the Summary of Benefits and Coverage ("SBC") requires a 60-day advanced notice. If the plan is subject to ERISA, it may also require a Summary of Material Reduction ("SMR") in benefits within 60 days following the reduction in coverage (the SMR requirements are met with the delivery of an updated SBC). If plans choose to do nothing, no participant notice is required.

Coverage of Coronavirus Vaccine

Since the ruling had no impact on immunizations recommended by ACIP, the order does not impact the requirement for plans to continue to cover the COVID-19 vaccine and any approved COVID-19 boosters without member cost-sharing.

Impact on High Deductible Health Plans

For a plan to be considered a high deductible health plan ("HDHP") (used in connection with a health savings account ("HSA")), it cannot provide any benefits before the applicable minimum deductible for that year has been satisfied. There is a safe harbor that allows an HDHP to cover certain preventive care before the deductible. While many of the preventive care services that the IRS includes in the safe harbor are also services that are covered by the USPTF recommendations, a plan will be able to continue the status quo until further guidance is issued. In other words, providing coverage for "A" and "B" recommended preventive care items and services before the deductible is met will not disqualify the HDHP or jeopardize an individual's HSA eligibility.

Employer Action

With the DOL appealing the court's decision, the litigation on these issues is not over. It could be the Supreme Court that ultimately decides whether the "A" and "B" recommendations of the USPTF can continue to be enforced. Moreover, further legal challenges may continue with respect to other aspects of the preventive care mandate, including coverage for contraceptives and ACIP recommendations on vaccines.

At this point, it is too early to tell whether carriers and plans will make broad changes to covered preventive care items and services as a result of the court's decision. If employers elect to make changes to their plans to eliminate coverage or apply cost-sharing with respect to the affected "A" and "B" items and services, they should abide by the respective notice requirements and do so in accordance with state law (fully insured plans). All employers should watch for further guidance clarifying uncertainties that exist as a result of this ruling.

IRS Explains High Standards For Substantiating FSA Claims

Issued date: 05/16/23

The IRS recently released a Chief Counsel Advice ("CCA") which addressed numerous situations regarding the substantiation of claims under a health flexible spending account ("FSA") and a dependent care FSA. A CCA is issued by the IRS's Office of Chief Counsel generally to an IRS field office in response to a request for assistance related to a taxpayer. While a CCA cannot be used or cited as precedent, it provides useful information on the Office's position on tax issues. Specifically, the IRS concluded in the CCA that when any expense of an employee is reimbursed by an FSA without being properly substantiated, the amount of the reimbursement is included in the gross income of such employee, including situations of:

- Expenses only self-certified by the employee;
- Substantiation only by random sampling;
- De minimis reimbursements without substantiation;
- No substantiation of charges from favored providers; and
- Advance substantiation for dependent care FSA expenses.

While the CCA does not reveal any new information, it serves as a reminder of the importance of proper substantiation of claims when using a health FSA and/or a dependent care FSA and the consequences for failing to have proper procedures in place.

Background

Internal Revenue Code sections 105(b), 125, and 129, and related regulations, set forth general rules allowing employers to set up FSAs for health care and dependent care expenses for employees, essentially through a cafeteria plan of an employer. If proper rules are followed:

- Employees can fund FSAs through salary reduction elections, which reduce their gross income for purposes of federal income taxes, state income taxes (most states), and FICA; and

- Employee expenses can be reimbursed for health care and dependent care expenses, including through the use of a debit card, and such reimbursements are not included in the employee's gross income.

A core component of the tax-favored treatment of these programs is that employees adequately substantiate all claims. Thus, the failure to meet the substantiation requirement can result in the loss of the employees' tax benefits from the FSA. Further, it can result in the cafeteria plan losing its tax-favored status – resulting in the loss of tax-favored treatment of employees' salary reduction elections for any benefits elected through the cafeteria plan.

The CCA

The CCA addressed two broad issues:

1. Must medical expenses reimbursed to an employee under a health FSA, where such expenses are not substantiated pursuant to guidance, be included in an employee's gross income?

2. Are expenses properly substantiated when certain short-cuts are allowed, or when dependent care expenses are substantiated only before they are incurred?

The CCA addressed six separate situations, one of which clarified what may be considered as compliant with substantiation requirements, and the other five illustrating situations that would fall short of meeting such requirements:

Example of meeting the substantiation requirements

A cafeteria plan with a health FSA and several features, all of which resulted in the IRS concluding the arrangement met substantiation requirements:

- Expenses are substantiated by information from an independent third party, which could include an explanation of benefits ("EOB") from an insurance company.

- The information describes:

    - The service or product;

    - The date of service or sale; and

    - The amount of the expense, including the employee's share through an EOB.

- The plan requires employees to certify that any expense paid by the plan has not been reimbursed by insurance or otherwise and that the employee will not seek reimbursement from any other plan covering health benefits.

- Debit cards can be used for reimbursements when meeting the requirements of proposed cafeteria plan regulations.

Examples of not meeting the substantiation requirements

- **Self-certification.** A health FSA that includes a feature where only the employee provides information regarding a claim for reimbursement of medical expenses, without a statement from an independent third party verifying the expenses, does not meet substantiation requirements. Notably, the CCA references the proposed regulation that prohibits self-substantiation of medical claims.

- **Sampling.** A health FSA with a debit card feature where the plan only requires substantiation of a random sample of charges. The CCA clarified that this too falls short of meeting substantiation requirements and included citation to guidance holding that sampling does not meet substantiation requirements.

- **De minimis.** A health FSA with a debit card feature does not require substantiation for charges below a specified dollar amount. Again, the CCA clarified that this fails to meet substantiation requirements and included a citation to a proposed regulation requiring substantiation for all claims, regardless of the amount.

- **Favored providers.** A health FSA with a debit card feature requires no substantiation for charges from certain dentists, doctors, hospitals, or other health care providers. The CCA emphasized that all claims must be substantiated.

- **Advance substantiation for dependent care FSA.** A dependent care FSA automatically reimburses employees for dependent care expenses when the employee has previously indicated such expenses would be incurred and the employee has not affirmatively notified the plan sponsor that such expenses were, in fact, incurred. The CCA makes clear that claims made in advance, without additional verification, do not meet substantiation requirements. It also notes the proposed regulations prohibit reimbursement of dependent care expenses before they have been incurred (i.e., merely formally being billed, or prepaying, is not sufficient) and without substantiating that they have been incurred.

Employer Action

While the substantiation requirements are not new, this is a good opportunity for employers to discuss and review substantiation procedures with FSA administrators, to ensure they are requiring full and proper substantiation of all claims for reimbursement, in keeping with existing guidance.

2024 Inflation Adjusted Amounts For HSAs

Issued date: 05/31//23

The IRS released the inflation adjustments for health savings accounts ("HSAs") and their accompanying high deductible health plans ("HDHPs") effective for calendar year 2024, and the maximum amount that may be made available for excepted benefit health reimbursement arrangements ("HRAs"). All limits increased from the 2023 amounts.

Annual Contribution Limitation

For calendar year 2024, the limitation on deductions for an individual with **self-only coverage** under a high deductible health plan is **$4,150**; the limitation on deductions for an individual with **family coverage** under a high deductible health plan is **$8,300**.

High Deductible Health Plan

For calendar year 2024, a "high deductible health plan" is defined as a health plan with an **annual deductible that is not less than $1,600 for self-only coverage** or **$3,200 for family coverage**, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) **do not exceed $8,050 for self-only coverage** or **$16,100 for family coverage**.

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year (i.e., a fiscal year HDHP), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. See IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-86 (Aug.16, 2004).

Catch-Up Contribution

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined by the statute, is $1,000 for 2009 and thereafter.

Excepted Benefit HRA Adjustment

For plan years beginning in 2024, the maximum amount for an excepted benefit HRA that may be made newly available for the plan year is **$2,100**.

Fixed Indemnity Policy Proceeds Are Taxable To Employees

Issued date: 06/16//23

On June 9, 2023, the IRS issued guidance on the taxation of fixed-indemnity health insurance policies that provide payments to participating employees when they complete a health-related activity that is available at no cost or is covered by other insurance. These programs are often marketed as “no-cost wellness programs” that promote “tax free” reimbursements with the potential to provide significant payroll tax savings to employees and the employer. This guidance reinforces the IRS’ earlier concern about the tax treatment of these arrangements.

The guidance concludes that the employer must treat payments to employees under the fixed-indemnity policy as taxable wages.

Details About the Fixed-Indemnity Policy

According to the guidance, the employer, through this arrangement, maintains:

- a group health insurance policy that offers comprehensive health benefits, including preventive care (such as flu vaccinations) without cost-sharing, and
- a fixed-indemnity health insurance policy.

Employees may enroll in one or both options, or neither option. The fixed-indemnity policy has the following terms and conditions:

1. Each participating employee makes a monthly pre-tax contribution of $1,200 through the employer’s section 125 cafeteria plan to pay for the employee’s coverage under the fixed-indemnity policy.

1. The employer forwards the entire $1,200 contribution to the insurance carrier to pay the premium for the fixed-indemnity policy on the employee's behalf. The employer is not liable for any additional premium payments under the policy.

2. In return for the premium payment, the insurance carrier provides the following benefits to the employee under the fixed-indemnity policy:

    a. A benefit for each day that the employee is hospitalized.

    b. Wellness counseling, nutrition counseling, and telehealth benefits at no additional cost.

    c. Payment of $1,000 (limited to one payment per month) if the employee participates in certain health or wellness activities. The employee's use of preventive care (such as vaccinations), which are available without cost-sharing under the employer's comprehensive group health insurance policy, would qualify the employee for the payment, as would the free wellness counseling, nutrition counseling, and telehealth benefits that are available under the fixed-indemnity policy. The employee would be responsible for paying the cost of any other health or wellness activity that is intended to qualify the employee for the $1,000 payment.

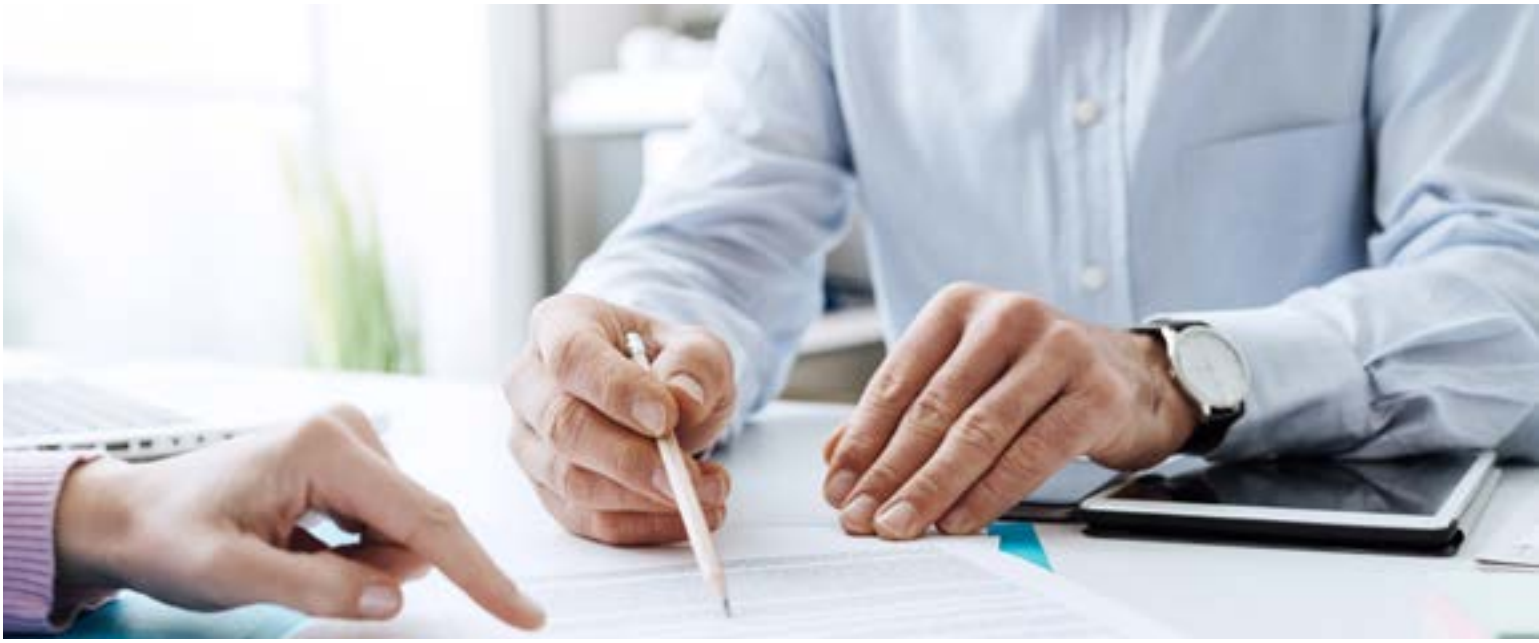
4. When an employee qualifies for the $1,000 payment under the fixed-indemnity policy, the insurance carrier pays the money to the employer, which then pays the money to the employee via its payroll system.

Taxation of Payments Under the Fixed-Indemnity Policy

The IRS concludes in its guidance that the employer must treat the $1,000 payments to participating employees under the fixed-indemnity policy **as taxable wages**, because the payments are remuneration for employment under benefit plans funded by the employer through its section 125 cafeteria plan and exceed the amount of the actual expenses for medical care. Therefore, under Code sections 104 and 105, and accompanying regulations, the employer is required to report the payments as taxable income to the employees on IRS Form W-2, and to withhold income taxes and FICA taxes on the payments. The employer is also required to pay its share of FICA taxes, as well as FUTA taxes, on the payments.

Employer Action

Employers that may have implemented a fixed-indemnity program that provides "tax free" wellness benefits should carefully review the program in light of the recent IRS guidance and should work with their tax professionals to comply with the employer's tax reporting and collection responsibilities under this new guidance.



2023 PCOR Fee Filing Reminder For Self-Insured Plans

Issued date: 06/20/23

The Patient-Centered Outcomes Research ("PCOR") fee filing deadline is **July 31, 2023**, for all self-funded medical plans and some HRAs for plan years (including short plan years) ending in 2022. Carriers are responsible for paying the fee for insured policies. The IRS issued Notice 2022-59 on November 14, 2022, announcing the adjusted fee amount for this year.

The plan years and associated PCOR fee amounts due July 31, 2023, are as follows:

Plan Year END Date	PCOR Fee Amount
January 31, 2022	$2.79/covered life/year
February 28, 2022	$2.79/covered life/year
March 31, 2022	$2.79/covered life/year
April 30, 2022	$2.79/covered life/year
May 31, 2022	$2.79/covered life/year
June 30, 2022	$2.79/covered life/year
July 31, 2022	$2.79/covered life/year
August 31, 2022	$2.79/covered life/year
September 30, 2022	$2.79/covered life/year
October 31, 2022	**$3.00/covered life/year**
November 30, 2022	**$3.00/covered life/year**
December 31, 2022	**$3.00/covered life/year**

Employers with self-funded health plans ending in 2022 should use the 2nd quarter Form 720 to file and pay the PCOR fee by July 31, 2023. The information is reported in Part II.

IRS Form 720 is a quarterly form that is used to report and pay many different taxes, including fuel and other transportation excise taxes. The IRS has adapted the Form 720 to be used for this annual reporting requirement. Each year, the PCOR section is updated with the fee rates in June for the July 31st due date (the 2nd quarter form).

Please note, Form 720 is a tax form (not an informational return form such as Form 5500), and as such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third-party administrators and USI, cannot report or pay the fee.

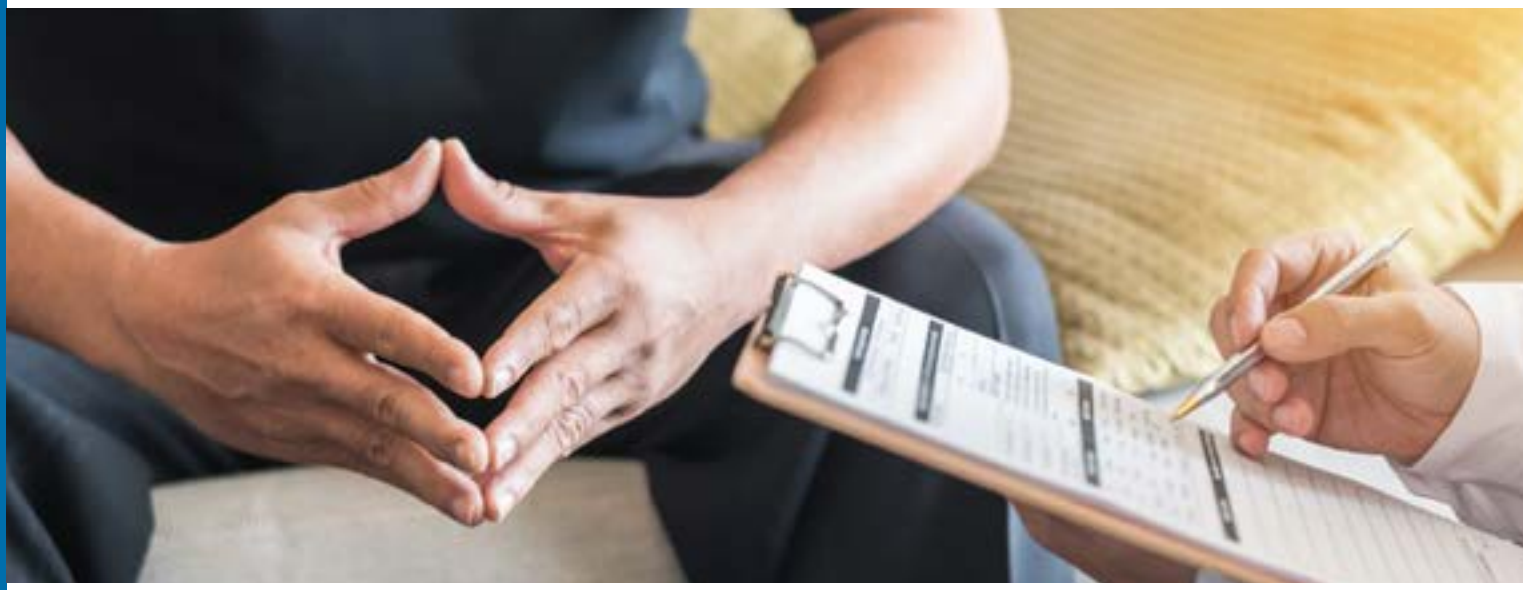
Resources

For a copy of Notice 2022-59, visit https://www.irs.gov/pub/irs-drop/n-22-59.pdf

For a copy of the regulations, visit: http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf

For additional information, please visit the following IRS sites:

- Form 720, Quarterly Federal Excise Tax Return, instructions and forms: https://www.irs.gov/forms-pubs/about-form-720
- Patient-Centered Outcomes Research Trust Fund Fee, Questions and Answers: https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee
- PCOR Filing Due Dates and Applicable Rates Chart: https://www.irs.gov/affordable-care-act/patient-centered-outreach-research-institute-filing-due-dates-and-applicable-rates



MHPAEA Exemption Ends for Self-Funded Governmental Health Plans

Issued date: 06/29//23

The Centers for Medicare and Medicaid Services ("CMS") released guidance to states, counties, school districts, municipalities, and other non-federal governmental entities that sponsor a self-funded group health plan, concerning the end of the optional exemption from the Mental Health Parity and Addiction Equity Act ("MHPAEA").

According to the CMS guidance, sponsors of a self-funded non-federal governmental group health plan that had previously opted out of MHPAEA are generally required to comply with the MHPAEA requirements beginning with the first plan year commencing on or after June 27, 2023. However, a special rule applies to collectively bargained plans which can result in a delay to the sunset date for a limited time if certain requirements are met.

Background

The sponsor of a self-funded non-federal governmental group health plan is generally permitted under the Health Insurance Portability and Accountability Act ("HIPAA") and the Affordable Care Act to make an election to opt-out of the following four requirements of the Public Health Services Act:

- Standards relating to benefits for newborns and mothers
- Required coverage for reconstructive surgery following a mastectomy
- Coverage for dependent students on a medically necessary leave of absence
- MHPAEA requirements

The Consolidated Appropriations Act of 2023, which was enacted into law on December 29, 2022, included a sunset provision that eliminates the ability of self-funded non-federal governmental group health plans to opt out of compliance with MHPAEA. As a result, sponsors of a self-funded non-federal governmental group health plan may only continue to opt out of the first three requirements of the Public Health Services Act set forth above. (Opt-out elections are not available for fully insured group health plans sponsored by a non-federal government entity.) MHPAEA generally requires that a group health plan provide mental health and substance use disorder benefits in parity with medical and surgical benefits in the same classification.

Sunset Date for the Opt-Out Election

According to the CMS guidance, no election to opt out of compliance with MHPAEA may be made by the sponsor of a self-funded non-federal governmental group health plan on or after December 29, 2022.

In addition, the CMS guidance states that no election to opt out of MHPAEA that expires on or after June 27, 2023 may be renewed, except as permitted under the special rule for collectively bargained plans.

Special Rule for Collectively Bargained Plans

The CMS guidance contains a special rule that applies to self-funded non-federal governmental group health plans that meet both of the following requirements:

- The plan is subject to multiple collective bargaining agreements of varying lengths; and
- The plan made an opt-out election for MHPAEA that was in effect on December 29, 2022, and that expires on or after June 27, 2023.

Under the special rule, collectively bargained plans that meet the above requirements may extend their election to opt out of MHPAEA until the date on which the term of the last collective bargaining agreement expires. To take advantage of this special rule, the sponsor must follow these steps:

1. The sponsor must send an email to CMS at HipaaOptOut@cms.hhs.gov, along with copies of the collective bargaining agreements and the self-funded group health plan document; the email must identify the effective date and termination date for each collective bargaining agreement, and the provisions which indicate that the collective bargaining agreements encompass the self-funded plan.

2. CMS will review the email and documents and notify the sponsor of its decision regarding application of the special rule to the sponsor's self-funded plan.

3. The sponsor must then submit a renewal opt-out (for MHPAEA) to CMS via HIOS by a specified date to extend the plan's existing opt-out. The renewal must be filed with CMS via HIOS before the first day of the plan year governed by the collective bargaining agreement, or by the 45th day after the latest applicable date of the term of the collective bargaining agreement (if the 45th day falls on or after the first day of the plan year).

4. The sponsor must also continue to comply with all other opt-out requirements, including the requirement to provide proper notice to enrollees.

Employer Action

The sponsor of a self-funded non-federal governmental group health plan that previously made an election to opt out of compliance with MHPAEA should take steps to make sure that the plan complies with MHPAEA's requirements by the sunset date for the opt-out election.

If the self-funded plan is subject to multiple collective bargaining agreements, the sponsor should work with its attorney or legal consultant to determine whether the special rule for a temporary extension of the opt-out election can apply to the plan. If the special rule can apply, the sponsor should follow the procedures outlined above to extend the opt-out election.

California Makes Changes to its SDI Program

Issued date: 07/05//23

California's State Disability Insurance (SDI) Program has several upcoming changes, including:

- Beginning January 1, 2024, the wage ceiling for employee SDI payroll contributions is eliminated.
- Beginning January 1, 2025, the wage replacement rate for short-term disability benefits and paid family leave benefits is increased to 70-90% (from 60-70%) depending on income, up to a maximum weekly benefit.

Background

California's State Disability Insurance (SDI) program provides both short-term Disability Insurance (DI) and Paid Family Leave (PFL), which are temporary wage replacement benefits paid from the state to eligible employees who need to be absent from work for specified reasons.

- Under DI, after a 7-day waiting period, California employees who are unable to work because of a non-work-related illness, injury, or pregnancy may be eligible for up to 52 weeks of disability insurance benefits of 60-70% of wages (depending on income), up to a maximum weekly benefit ($1,620/week in 2023).
- Under PFL, California employees who need time off from work to care for a seriously ill family member, to bond with a new child, or to participate in a qualifying exigency related to covered active duty of the employee's family member, may be eligible for up to 8 weeks of paid family leave benefits of 60-70% of wages (depending on income), up to a maximum weekly benefit ($1,620/week in 2023).

This 60-70% wage replacement rate for DI/PFL benefits was scheduled to expire at the end of 2022 and revert back to 55% of wages (as it was in 2017).

Eligible employees pay for their participation in the DI and PFL programs by making payroll contributions to California's state disability insurance.

- In 2023, employees contribute 0.9% of pay up to a wage ceiling of $153,164; the maximum withholding from an employee is $1,378.48 in this year.

- In 2022, employees contributed 1.1% of pay up to a wage ceiling of $145,600; the maximum withholding from an employee was $1,601.60 in this year.

An employer that has applied to and received approval from California's Employment Development Department (EDD) may maintain a voluntary plan to provide short-term disability insurance and paid family leave to its employees, in lieu of its employees participating in the state program

New Developments

In September 2022, Governor Newsom signed Senate Bill 951 into law, which made three important changes to California's SDI Program.

First, SB 951 extended the 60-70% wage replacement rate for DI/PFL benefits through the end of 2024.

Second, beginning January 1, 2025, the wage replacement rate for DI/PFL benefits will increase to 70-90% of weekly wages, depending on the employee's income. This change will primarily affect lower paid employees whose weekly benefit is less than the maximum weekly benefit.

Finally, in order to fund this increase in DI/PFL benefits, the wage ceiling on employee SDI payroll contributions is eliminated, beginning January 1, 2024 (i.e., one year before the increase in DI/PFL benefits). This means all California wages will be subject to withholding for SDI payroll contributions, without regard to any wage ceiling or cap. This change will only affect employees who earn more than the existing wage cap on SDI payroll contributions ($153,164 in 2023).

It is important to note that these changes also apply to an employer that maintains a voluntary plan to provide short-term disability insurance and paid family leave to its employees in lieu of the state program. For example, the voluntary plan's benefits must be amended to match the increases to the state-provided DI and PFL benefits.

Minnesota Passes Paid Family and Medical Leave Law

On May 25, 2023, Minnesota became the 12th state to provide paid family and medical leave ("PFML"). Starting January 1, 2026, eligible employees will be able to apply for up to 20 weeks of paid leave with the Minnesota Department of Employment and Economic Development ("DEED").

Covered Employers

Any employer with at least one employee working within Minnesota must provide PFML. This includes most private and public employers such as school districts and city/county public entities. Self-employed individuals and independent contractors may opt into the program. Seasonal hospitality employees (i.e., those that work less than 150 hours per year) are not eligible for PFML benefits.

Eligible Employees

Eligible employees have work and wage requirements. Eligible employees are those persons that either:

- Work at least 50% of their time within Minnesota;
- Do some of their work in Minnesota and reside within Minnesota for at least 50% of the calendar year; or
- Neither work or reside in Minnesota but the place where their work is directed from is located in Minnesota.

In addition, Minnesota employees must earn at least $3,500 in wages (from a single employer or multiple employers) within a period of 12 consecutive months prior to applying for paid leave.

Types of Leaves

The law classifies eligible leave into two categories (i) family leave, and (ii) other leave, with each providing up to 12 weeks of leave in a benefit period, although an employee may take up to 20 weeks of combined leave in a 12-month benefit period. The qualifying leave events are:

Family leave:

- Serious health condition for the employee.
- Pregnancy and parental leave, including bonding with a new biological, adopted or foster child.
- Care of family member's or military member's serious health condition.

Other leave:

- To care for self or family member's domestic assault, sexual assault, and/or stalking (includes legal assistance and household relocation).
- Qualifying exigencies, such as imminent departure of family member to active military duty.

To be eligible, the qualifying event must have an expected duration of at least seven days (except for bonding with a new child) and will be considered to be taken consecutively unless the event is identified as intermittent on the PFML application.

PFML defines "family member" as the employee's:

- spouse, domestic partner, child (including in loco parentis, legal guardian, and "de facto" parent), parent/legal guardian, sibling, grandparent (including spouse's grandparent), grandchild, son/daughter-in-law; and
- an individual who has a relationship with the applicant that creates an expectation and reliance that the applicant cares for the individual, whether or not the applicant and the individual reside together.

Additional guidance will be necessary on how to properly test or confirm the existence of such a relationship. Presumably, this broad definition incorporates leave for such persons as domestic partners, which is something that FMLA does not cover.

Contributions and Benefits

Starting January 1, 2026, employers will contribute 0.7% of employee wages, although employers can opt to pay the entire amount or elect to have employees pay up to 50% of the required premiums.

The PFML benefit is based upon a percentage of the employee's wages and the state's average weekly wage. Workers can expect to receive:

- 90% of their weekly wages that are less than or equal to 50% of the stage's average weekly wage);
- 66% of their weekly wages that is greater than 50% of the state's average weekly wage but less than 100% of the state average weekly wage; or
- 55% of their weekly wages that is more than 100% of the state average weekly wages.

An employer cannot require that the employee use their accrued PTO, sick and/or vacation time at the same time as PFML or instead of PFML Employees can however choose to use their accrued paid time off ("PTO"), sick and/or vacation time instead of the PFML and the PFML protections will still be in effect for the individual. An employer can choose to provide supplemental benefit payments to compensate employees to their normal compensation amounts.

Starting July 1, 2025, employers will be able to substitute state-approved private plans instead of participating in the state program. Additional guidance on the process will be forthcoming but private plans are expected to include a surety bond.

Notice Requirements and Retaliation Prohibition

Employers are required to post a notice in the workplace about the PFML in both English and the primary language of 5 or more employees. Employers are also required to provide newly hired employees with written notice on their expected PFML benefit amount and instructions on how to apply for the benefits. DEED is expected to produce a template for employers.

Employees are required to provide notice to the employer at least 30 days in advance of their intent to apply for a foreseeable leave or as soon as practicable for an unforeseeable leave. The employer can still require the employee to follow their normal call-in/reporting procedures if they do not unnecessarily interfere with the employee's ability to apply for the leave.

Employers are prohibited from retaliating against employees for utilizing their paid leave. Employees that were hired at least 90 days prior to using their leave have the right to be reinstated with their employer into either their same job or an equivalent job. Similar to FMLA, employees retain access to their health insurance while on paid leave.

Employer Action

Employers should begin to determine if they have employees that will be eligible for this future leave benefit. Creating a process to track eligibility would be prudent and to develop a process to provide the required written notice to new hires.

Employers may want to review their existing leave policies and handbooks to see if there is any potential overlap with the new requirements. This may be especially important for multi-state employers that have attempted to create uniform leave policies to satisfy the different leave laws in these jurisdictions.

DEED is currently drafting frequently asked questions and additional guidance for employers and employees. Employers may want to sign up for their newsletters to keep up with the most recent updates.

New Mexico to Continue COVID-19 Coverage After Emergency Ends

With the federal Public Health Emergency ending May 11, 2023, many plans will be adding patient cost sharing for COVID-19 testing. However, some states require insurance policies issued in their state to continue to cover COVID-19 testing with no patient cost share. New Mexico is one of those states.

COVID-19 and Flu-Related Coverage

The change began with an emergency order from the Office of Superintendent of Insurance (of New Mexico). New Mexico since enacted a state insurance law that prohibits any cost sharing requirement for the provision of testing and delivery of health care services for COVID-19 (including testing/screening for pneumonia and influenza, treatment for pneumonia when due to or a result of COVID-19 infection, and treatment for influenza when a co-infection with COVID-19) or any disease or condition which is the cause of, or subject of, a public health emergency. For purposes of this rule, a public health emergency exists when declared by the state of New Mexico or the federal government. Even though the federal Public Emergency is ending May 11, 2023, and the New Mexico state Emergency Period is ending March 31, 2023, this rule applies permanently, unless amended.

Application to Group Health Plans

The New Mexico insurance law requirement set forth above applies to group health insurance policies (includes HMOs) issued or delivered (i.e., situsued) in New Mexico. The New Mexico law does not apply to fully insured plans written outside New Mexico or to self-funded medical plans.

Employer Action

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

Status of Oklahoma's Patient's Right to Pharmacy Choice Act

In 2019, Oklahoma passed the Patient's Right to Pharmacy Choice Act (the "Act") which restricts what pharmacy benefit managers ("PBMs") can do. This article summarizes the Act and describes where it is today given an update, a legal challenge, and an enforcement action.

The Act

In part, under the Act, PBMs must comply with certain retail pharmacy network access standards and cannot:

- use mail-order pharmacies to meet access network access standards;
- restrict an individual's choice of an in-network provider for prescription drugs;
- incentivize patients to fill prescriptions through mail order rather than their pharmacy of choice;
- require patients to use pharmacies that are directly or indirectly owned by the PBM;
- deny a pharmacy the opportunity to participate in any pharmacy network at preferred participation status if the pharmacy is willing to accept the terms and conditions that the PBM has established for other pharmacies; or
- restrict any pharmacy from informing an individual of any differential between the individual's out-of-pocket cost outside insurance.

It was effective September 1, 2020.

In April 2022, SB 737 updated the Act to prohibit spread pricing in Oklahoma, effective immediately. Oklahoma statutes define spread pricing as a prescription drug pricing model in which the PBM charges a health benefit plan a contracted price for prescription drugs that differs from the amount the PBM directly or indirectly pays the pharmacy or pharmacist.

Preemption

The Act was challenged by the Pharmaceutical Care Management Association ("PCMA"), the trade lobby for PBMs, as being preempted by ERISA. In April 2022, the federal district court concluded that there is no "connection with" an ERISA plan. Previously, the U.S. Supreme Court unanimously upheld a similar Arkansas law regulating PBMs against an ERISA preemption challenge in Rutledge v. PCMA, 141 S. Ct. 474 (2020). PCMA has appealed to the U.S. Tenth Circuit Court of Appeals. Oral arguments occurred on May 16, 2023 and a decision is expected in the near future.

Jurisdiction

Although the court did not specifically address the precise application, the view of the Oklahoma Insurance Department ("OID") is that the law is intended to protect all Oklahoma residents, regardless of whether the plan involved is:

- an Oklahoma based plan; or
- an out-of-state plan providing coverage to Oklahoma residents.

This includes self-funded plans.

Enforcement Action

The OID is taking enforcement action against PBMs operating in violation of the Act, even while it is being challenged in the courts. On January 20, 2022, the OID announced that it entered into a Settlement Agreement with CVS Caremark regarding its collection of transaction fees from pharmacies for Medicare Part D and ERISA plan claims. Under the terms of the agreement, CVS Caremark paid the state of Oklahoma $4.8 million. In addition, letters were supposed to be sent out by CVS Caremark to consumers explaining their options for prescriptions. Instead, in March 2023, CVS Caremark claimed that the law does not allow for the filling of 90-day supply prescriptions and turned off mail service access for all Oklahoma-based members. CVS then revisited this position and now allows 90-day fills at any willing pharmacies. To their understanding of OID requirements, this benefit design is opened up to allow any willing pharmacy to dispense a 90-day supply of drugs – including CVS's own mail order pharmacy.

Employer Action

No action is required, but employers may want to keep their eye on this law and similar laws affecting their benefit program offerings.

Texas' Implementation of the Federal No Surprises Act

The federal No Surprises Act ("NSA") prohibits balance billing in certain circumstances where there are out-of-network ("OON") charges and applies to all medical plans. Texas has a similar law that currently applies only to insured medical plans in Texas. Note that this does not include level-funded health plans, but does include non-federal governmental plans that are not subject to Texas' balance billing laws which may include plans for employees of state universities, and school districts that have opted out of participation in the Teacher Retirement System health plan

Texas HB 1592 was signed into law on June 14, 2023, and allows ERISA-covered self-funded medical plans to utilize Texas' balance billing and out-of-network dispute resolution requirements, effective September 1, 2023. A self-funded health plan would need to submit an annual election opting into the state's balance billing protections to the Texas Insurance Commissioner ("Commissioner"). The form and manner are not yet determined, but, not later than December 1, 2023, the Commissioner must adopt rules necessary to implement the change in law.

The following is a chart summarizing how each system works:

	Federal	Texas	Comments
Covered services	• Emergency services performed by an OON provider and/or at an OON facility and for post-stabilization care after an emergency if the patient cannot be moved. • Non-emergency services performed by OON providers at in-network facilities (includes hospitals, ambulatory surgical centers, labs, radiology facilities and imaging centers).	• Emergency care provided in a hospital emergency facility, free-standing emergency medical care facility, or comparable emergency facility. • Services provided by out-of-network providers at in-network facilities.	The types of covered services are very similar except that Texas does not handle air ambulance charges and in Texas, patients cannot waive their rights against balance billing.

	• Air ambulance services provided by OON providers. There is a limited exception as it relates to certain non-emergency and non-ancillary services where informed consent is obtained.	• Out-of-network pathology/ laboratory services when the provider has not disclosed the price to the patient. • Radiology imaging that includes CTs, PET Scans, MRIs, or any combination of those technologies when the provider has not disclosed the price to the patient. The Federal IDR process applies to air ambulance services furnished by OON providers.	
Initial payment	The initial payment should be an amount that the plan or issuer reasonably intends to be payment in full based on the relevant facts and circumstances and as required under the terms of the plan.	The initial payment is the usual and customary rate.	
Time to initiate independent dispute resolution (IDR)	If initial payment is not accepted, 30 days is given to begin a 30-day open negotiation period. If no agreement is reached, there are 4 days to declare initiation of IDR.	After 20 days from the date payment is received, either party can submit a case into the Texas IDR process.	
Arbitrator selection	The provider and plan jointly select an arbitrator within 3 business days after initiation of IDR. Otherwise, the Departments of the Treasury, Labor, and Health and Human Services select an arbitrator.	There are 30 days to select arbitrator by mutual agreement. Otherwise, the Texas Department of Insurance selects an arbitrator.	
Factors considered	1. The level of training, experience, and quality and outcomes measurements of the provider that furnished the item or service. Credible information should demonstrate the experience or level of training of a provider was necessary for providing the qualified IDR item or service to the patient, or that their	1. Whether there is a gross disparity between the fee billed by the out-of-network provider and: a. fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other enrollees for which the provider is an out-of-network provider; and	

	experience or training made an impact on the care that was provided. 2. The market share held by the non-participating provider or the plan in the geographic region in which the item or service was provided. Credible information should demonstrate how the market share affects the appropriate out-of-network rate. 3. The acuity of the individual receiving the item or service or the complexity of furnishing the item or service to the individual; the teaching status, case mix, and scope of services of the nonparticipating facility that furnished the item or service. Credible information should demonstrate how patient acuity or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee affects the appropriate out-of-network rate for the qualified IDR item or service. 4. Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or the plan to enter into network agreements and, if applicable, contracted rates during the previous four plan years. For example, a certified IDR entity should consider what the contracted rate	b. fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region; 2. The level of training, education, and experience of the out-of-network provider; 3. The out-of-network provider's usual billed charge for comparable services or supplies with regard to other enrollees for which the provider is an out-of-network provider; 4. The circumstances and complexity of the enrollee's particular case, including the time and place of the provision of the service or supply; 5. Individual enrollee characteristics; 6. The 80th percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database; 7. The 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area;	

	might have been had the good faith negotiations resulted in the out-of-network provider or facility being in-network, if a party is able to provide related credible information of good faith efforts or the lack thereof.	8. The history of network contracting between the parties; 9. Historical data for the percentiles described by (6) and (7) above; and 10. An offer made during the required informal settlement teleconference.	
Style of negotiation	Baseball style arbitration	Baseball style arbitration	Baseball style arbitration means that either the provider's requested amount or the TPA's/carrier's requested amount is chosen by the arbitrator; an amount between the two or any other amount is not an option.

Employer Action

No employer action is required. Employers with self-funded medical plans considering opting into the Texas system should await additional guidance.

Coverage for Hearing Instruments Under New Washington Law

Under a new Washington insurance law, non-grandfathered large group health plans issued or renewed on or after January 1, 2024, will be required to provide coverage for hearing instruments, except over-the-counter ("OTC") instruments, including bone-conduction hearing devices. This requirement also applies to health plans offered to public employees and their dependents issued or renewed on or after January 1, 2024.

This coverage requirement does not apply to:

- Small group insurance; and
- ERISA self-funded group health plans.

Briefly:

- Coverage must include the hearing instrument, the initial assessment, fitting, adjustment, auditory training, and ear molds, as necessary, to maintain optimal fit.
- Coverage must be provided at no less than $3,000 per ear with hearing loss every 36 months.
- The benefit is not subject to the deductible. There is an exception for qualified high deductible health plans ("HDHP") used with a health savings account ("HSA"). In this case, the carrier may apply a deductible to the coverage, but only at the minimum level necessary to preserve HSA eligibility.
- Coverage for minors under age 18 is only available after the child has received medical clearance within the preceding 6 months from:
  - An otolaryngologist for an initial evaluation of hearing loss; or
  - A licensed physician, which indicates there has not been a substantial change in clinical status since the initial evaluation by an otolaryngologist.

Employer Action

Large employers with fully insured group health plans in Washington should anticipate this new coverage requirement with their first renewal on or after January 1, 2024.

Health plans offered to public employees should review existing coverage and update for applicable changes with the first renewal on or after January 1, 2024.

It's unlikely this coverage change will materially impact rates.

Expect to see additional communications from your carriers as renewal approaches.

WA Cares Fund Payroll Tax Begins July 1, 2023

As previously reported, beginning July 1, 2023, a 0.58% premium assessment applies on the wages of all Washington employees to fund Washington's Long-Term Services and Supports Trust Program (now referred to as "WA Cares Fund"). All wages are subject to the premium assessment; there is no cap. The WA Cares premium is paid by employees via a payroll tax, there is no required employer contribution.

After an initial delay by the state legislature, employees will begin paying the premium assessment on July 1, 2023. Recent efforts to repeal the program failed in the last legislative session.

Unless an employee has an approved exemption, employers should deduct premiums from each paycheck an employee receives on or after July 1, 2023, regardless of when the hours were earned.

Quarterly, employers must report employees' wages and hours and remit collected premiums to the Employment Security Department ("ESD"). The first report and premium payment for the WA Cares Fund is due by October 31, 2023 (for July, August, and September 2023 payroll). WA Cares premiums are collected in the same manner as premiums for Washington's Paid Family and Medical Leave program. ESD is updating the Paid Leave reporting system so employers can report for both programs at the same time.

ESD has developed materials that will be helpful to employers in understanding and communicating information about the WA Cares Fund. Much of this information can be found under the Employer link on the WA Cares Fund website https://wacaresfund.wa.gov/employers/, including an employer toolkit and helpful FAQs.

Employer Action

Employers should coordinate with payroll for processing and reporting for the WA Cares Fund.

Washington State Increases 2024 PAL Assessment

The Washington Health Care Authority ("HCA") will increase the PAL assessment amount for fiscal year 2024 to $0.07 per covered life per month (increased from $0.06) effective for payments due on November 15, 2023.

Background

As previously reported, Washington's Partnership Access Lines funding program ("WAPAL Fund," also known as the "PAL assessment"), an assessment-based program established to fund the costs for psychiatry and behavioral sciences referral lines, became effective on July 1, 2021. Washington's HCA is responsible for the enforcement of this provision.

The PAL Assessment applies to "assessed entities" – defined to mean:

- Health insurance carriers;
- Employers or other entities that provide health care in Washington, including self-funding entities or employee welfare benefit plans; and
- Self-funded multiple employer welfare arrangements.

A "covered life" means any individual residing in Washington with respect to whom the assessed entity administers, provides, pays for, insures, or covers health care services.

The assessment applies monthly and is paid quarterly following the end of the calendar quarter. Each year, HCA holds a rate-setting meeting to recommend the monthly assessment for the next fiscal year. The 2024 assessment of $0.07 applies with respect to payments due November 15, 2023, February 15, 2024, May 15, 2024, and August 15, 2024.

Employer Action

Employers sponsoring self-funded plans should confirm that they are reporting and paying the covered lives assessment at:

- the current 2023 rate of $0.06 for the payment due August 15, 2023, and
- the higher 2024 rate of $0.07 for the payment due on November 15, 2023

A third-party administrator ("TPA") may be assisting with this process.

Carriers are responsible for the payment for fully insured group health plans. No employer action is necessary.

MY BENEFIT ADVISOR

www.mybenefitadvisor.com

This document is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws or regulations, or to address specific client situations. You should not act or rely on any information contained herein without seeking the advice of an attorney or tax professional.

CA Insurance License 0C94240