Compliance Update

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Gag Clauses

What is a “gag clause”?

As per the CAA, a “gag clause” is defined as:

- Restrictions on the disclosure of provider-specific cost or quality of care information or data to parties such as the plan sponsor, participants, beneficiaries, or referring providers
- Restrictions on electronic access to de-identified claims and encounter information or data for each participant, beneficiary, or enrollee upon request and consistent with HIPAA, GINA, and ADA privacy regulations
- Financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract
- Provider information, including name and clinical designation
- Service codes or any other data element included in claim transactions
- Restrictions on sharing information or data or directing that such information or data be shared, with a business associate

The **“no gag clause”** rule applies to contracts between a plan and a health care provider, a network or association of providers, a third-party administrator (TPA), or another service provider offering access to a network of providers.

What does the “no gag clause” rule prohibit?

- The gag clause provisions of the CAA (specifically Code section 9824, ERISA section 724, and PHSA §2799A-9(a)(1)), generally prohibit plans and carriers from entering into agreements with providers, TPAs, or other service providers that include such provisions.

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Gag Clauses (cont'd)

What are some examples of gag clauses?

- A contract between a group health plan and a TPA that states that the plan will pay providers at designated "Point of Service Rates," but the TPA contractually prohibits the plan from disclosing the rates to participants.
- A contract between a group health plan and TPA that states the plan sponsor's access to provider-specific cost and quality-of-care information is only available at the TPA's discretion.

What is the Gag Clause Prohibition Compliance Attestation?

Under the Transparency provisions of the CAA, plans and issuers must annually submit to the Departments an attestation that the plan or issuer is in compliance with Code section 9824, ERISA section 724, and PHS Act section 2799A-9, as applicable (Gag Clause Prohibition Compliance Attestation). Gag Clause Attestation | Welcome! (cms.gov)

What is the due date for the Gag Clause Prohibition Compliance Attestation?

The first **Gag Clause Prohibition Compliance Attestation is due no later than December 31, 2023**, covering the period beginning December 27, 2020, or the effective date of the applicable group health plan or health insurance coverage (if later), through the date of attestation.

Subsequent attestations, covering the period since the last preceding attestation, are due by December 31 of each year thereafter.

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End of Covid-19 Emergencies

Back on January 30, the President announced his intention to end the COVID-19 National Emergency (NE) and Public Health Emergency (PHE) effective May 11, 2023. If you remember, both emergency declarations resulted in various forms of relief for employer-sponsored benefit plans, and both have been extended several times. Employers should be preparing for the end of the relief.

National Emergency – All of the following deadlines were extended by the length of the Outbreak Period and will **end on June 9, 2023:**

- HIPAA/CHIPRA Special Enrollment
- COBRA Notifications
- COBRA Elections
- COBRA Premium Payments
- Benefit Claims and Appeals
- External Review

On March 30, H.J. Res. 7 was voted on and passed in both the House and the Senate. This resolution would terminate National Emergency prior to the May 11 date. The President signed the resolution on April 10, and it is effective immediately.

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End of Covid-19 Emergencies (cont'd)

EXAMPLES

- **Electing COBRA –** If a participant experiences a qualifying event and is provided a COBRA election notice **before** the end of the outbreak period, the individual's 60-day period to elect COBRA begins to run on June 9, 2023, which makes the deadline August 7, 2023 regardless of whether the qualifying event, loss of coverage, or provision of the COBRA notice occurs before or after the end of the National Emergency. If the qualifying event occurs **after** the end of the outbreak period, there is no extension, and the 60-day period is measured from the date the COBRA election notice is provided.
- **Paying COBRA Premiums –** Assume that a COBRA election is made on October 15, 2022, retroactive to October 1, 2022. The initial COBRA payment, covering premiums from October 2022 through June 2023, must be made no later than 45 days after the end of the outbreak period which would be July 23, 2023. Subsequent payments would be due according to the regular COBRA timeline, the first day of each month of coverage, with a 30-day grace period.
- **HIPAA Special Enrollments –** For events giving rise to HIPAA special enrollment rights that occur before the end of the outbreak period, the special enrollment period begins to run on June 9, 2023. For example, an individual who gives birth to a child **before** the end of the outbreak period has until July 10, 2023, which is 30 days after the end of the outbreak period to exercise their special enrollment rights, regardless of whether the birth occurred before or after the end of the National Emergency. An individual who gives birth after the end of the outbreak period has 30 days after the date of the birth to exercise special enrollment rights.

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End of Covid-19 Emergencies (cont'd)

Public Health Emergency

- Under the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, employer-sponsored group health plans are required to cover COVID-19 testing, vaccines, and related services without cost-sharing.
- The end of the PHE may permit group health plans and insurers to shift some of these costs to participants. Before the PHE ends on May 11, 2023, group health plans should consider if they will continue offering these services without cost-sharing.
- Any potential change in coverage should be reviewed before the change is made to ensure proper participant notices and communications are timely distributed, and no issues arise under the Mental Health Parity and Addiction Equity Act.

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End of Covid-19 Emergencies (cont'd)

- Section 6001 of the FFCRA required plans and issuers to cover COVID-19 diagnostic tests without imposing any cost-sharing requirements, prior authorization, or other medical management requirements. However, that requirement was only applicable to diagnostic tests and associated items and services furnished during any portion of the PHE beginning on or after March 18, 2020. Therefore, a plan or issuer will not be required under section 6001 of the FFCRA to cover COVID-19 diagnostic tests and associated items or services furnished after the PHE ends.
- Any plan or issuer that provides coverage for COVID-19 diagnostic testing furnished after the PHE ends, including over-the-counter (OTC) COVID-19 diagnostic tests purchased after the PHE ends, is not prohibited from imposing cost-sharing requirements, prior authorization, or other medical management requirements for those items and services under section 6001 of the FFCRA.
- Coverage of COVID-19 preventive services (including vaccines) is still required. The CARES Act requires non-grandfathered plans to cover without cost-sharing any qualifying coronavirus preventive service within 15 business days after the date on which an applicable recommendation is made by the United States Preventive Services Task Force (USPSTF) or the Advisory Committee on Immunization Practices (ACIP). The Departments issued regulations under this provision that imposed additional requirements, including that the mandatory first-dollar coverage apply to both in-network and out-of-network services.
- This requirement to provide coverage of COVID-19 preventive services is not limited to the duration of the PHE and will continue in effect for non-grandfathered plans. A non-grandfathered plan must continue to provide first-dollar coverage of COVID-19 vaccines and other preventive services after the end of the PHE. However, similar to other preventive services, COVID-19 preventive services can be limited to in-network providers, unless the plan does not have an in-network provider that can provide a required service.
- Until further guidance is issued, any high-deductible health plan (HDHP) may continue to cover COVID-19 diagnostic testing upon the conclusion of the public health emergency, without jeopardizing the high-deductible status of the group health plan and HSA eligibility.

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End of Covid-19 Emergencies (cont'd)

We urge plan sponsors to consider the following:

- Make decisions regarding the coverage of COVID-19 diagnostic testing, vaccines, and related services.
- Communicate to and update participants on these coverage decisions.
- Inform participants that the extended deadlines will be replaced with pre-emergency deadlines at the end of the Outbreak Period.
- Review all plan-related documents and participant communications to ensure they reflect proper deadlines and coverage information. Plan sponsors that amended legal plan documents and/or summary plan descriptions to incorporate the requirements will need to amend plan documents and/or issue SMMs along with any participant communication materials.
- Any change that impacts the **summary benefits of coverage** will require 60-day advance notification.

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On the Legislative Horizon

The Commonsense Reporting Act **H.R. 1264** enables employers to report employer-sponsored health plan information to the IRS prospectively, before annual fall open-enrollment season in the state and federal exchanges instead of 14 months after that open-enrollment period and an entire coverage year has ended.

- Establish a new voluntary reporting system for employers to report to the IRS information about their health plans. Exchanges will use the federal data hub to access this data for individual verification for tax credits.
- Require that employers report to the IRS only those employees (and/or their dependents) who are not receiving healthcare from their employer, greatly simplifying the requirement that all employees be reported.
- Specify that information that would be reported would include name and employer identification, who has been extended an offer of minimum essential coverage, whether coverage meets minimum value and the affordability safe harbor, and months that coverage is available without waiting periods.
- Allow employers to deliver reports to employees electronically without another consent form.

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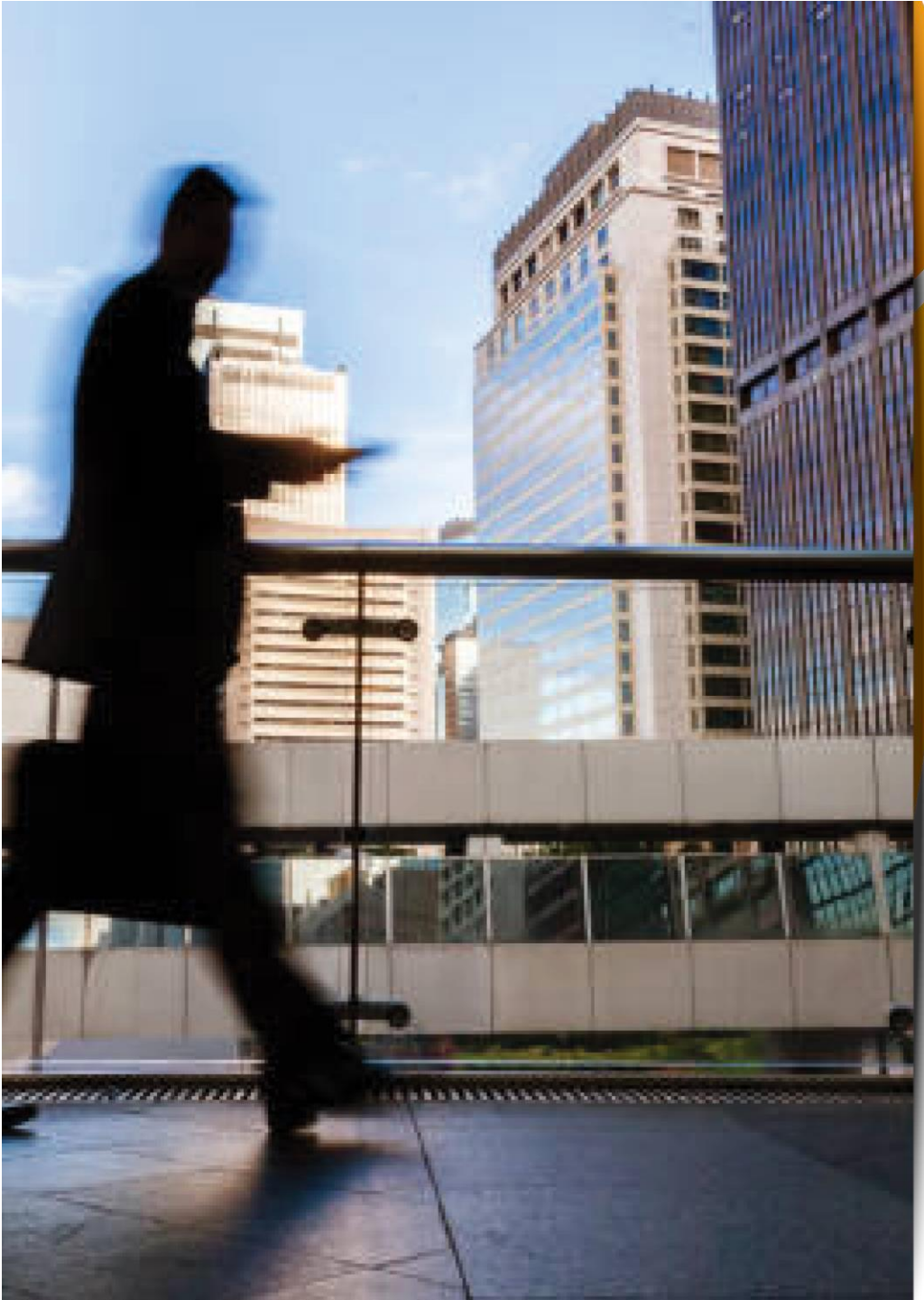

On the Legislative Horizon (cont'd)

- Instruct the Government Accountability Office to conduct a study on the notifications, HHS appeals process and the prospective reporting system.
- Require HHS to review the most recent tax filing for individuals automatically reenrolled in exchange-based coverage and adjust their tax credits accordingly.
- Limits the time horizon for IRS lookback for prior compliance period in accordance with current regulatory and statutory guidelines.

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Medicaid Unwinding

- In March 2020, as part of COVID-19 relief legislation, Congress provided increased Medicaid funding to states. States had to meet several conditions to receive the federal funds, collectively called a Maintenance of Effort (MOE) requirement, as well as a "continuous coverage" requirement that prohibited states from terminating most Medicaid enrollees' coverage until after the public health emergency (PHE) ended as determined by the Department of Health and Human Services.

- During the Public Health Emergency (PHE), Medicaid agencies could not disenroll anyone from Medicaid unless they ask to be disenrolled, move out-of-state, or die. Continuous coverage allowed millions of people to stay covered without any interruption during the pandemic.

- **"Unwinding"** is the process by which states will resume annual Medicaid eligibility reviews after the PHE ends. Medicaid agencies will first attempt to complete an automated renewal based on information available to them. If that is not possible, agencies then send renewal notices and requests for information to enrollees. When enrollees respond, agencies will process the cases, renew coverage for those who remain eligible, and notify those who are no longer eligible that their coverage will end.

- If enrollees don't respond, because they don't get the request for information due to having changed their address or phone number, or they don't understand what they are supposed to do, for example, their coverage will end.

- An estimated 18 million people could lose Medicaid coverage as part of the Medicaid unwinding. Arizona, Arkansas, Idaho, New Hampshire and South Dakota have already started the process which could take 12 to 14 months in each state.

- A link to the 50-state schedule for unwinding can be found here 50-State Unwinding Tracker – Center For Children and Families (georgetown.edu)

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Ruling on Preventive Care

A federal judge on Thursday struck down a key provision of the Affordable Care Act, ruling that certain aspects of the preventive care mandate violate the Constitution. A nationwide injunction has been issued.

The injunction will not have any immediate impact on employers with fully insured plans as those plans are approved by the state and the terms are likely locked in until renewal. Additionally, those fully insured policies may be subject to certain state preventive care mandate requirements.

For employers with self-insured group health plans, the injunction would allow employers the option to amend their plans to make changes, including implementing cost-sharing for the preventive care services impacted by the decision.

Among the services affected include:

- Screenings for cancer, mental health, HIV and diabetes
- Colonoscopies
- Pap smears
- Tobacco cessation services

The legal challenge was brought by eight individuals and two businesses, all from Texas. They argued that the free PrEP requirement requires business owners and consumers to pay for services that are counter to their religious beliefs.

The Justice Department is appealing the judge's decision.

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BenefitMall's Compliance & Legislative Team

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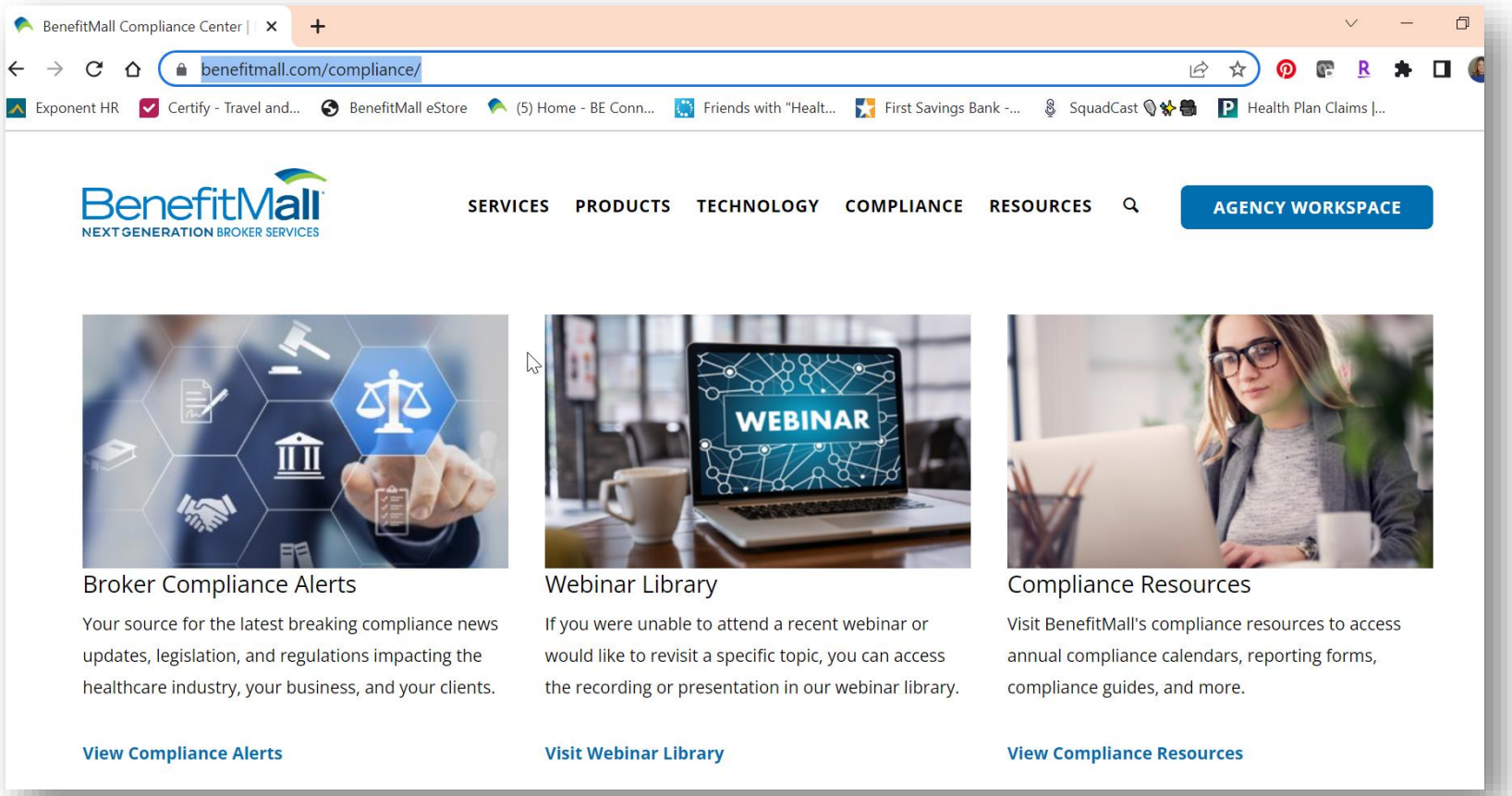

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Questions?

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