2022 Legislative & Regulatory Update

February 2022

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DISCLAIMER

The information herein should not be construed as legal or tax advice in any way.

This presentation is meant for informational and educational content only. Neither the presenter, or the sponsors, or sources referred to make any warranty of any kind concerning this information.

You should seek the advice of your attorney or tax advisor for specific information pertaining to any business.

Employer Exclusion

- The tax exclusion for employer-provided health coverage is **an important tax benefit for employees** and it provides the foundation for consumer driven health plans offered by employers. This exclusion exempts employer-provided health coverage from both income taxes and employment taxes.
- This tax exclusion is extremely costly–it reduces federal and state tax revenues **by $260 billion per year** and is the government's third largest expenditure on health care, after Medicare ($400 billion) and Medicaid ($300 billion).

Vaccine Requirements

- Under the CARES Act, non-grandfathered group health plans must cover COVID-19 vaccines without cost-sharing.
- Effective January 5, 2021, plans were required to cover without cost-sharing any COVID-19 vaccine authorized under an Emergency Use Authorization (EUA) or approved under a Biologics License Application (BLA) by the FDA immediately upon the vaccine becoming authorized or approved.
- Actual treatment of COVID-19 itself is not mandated. Some employers initially expanded the 100% cost-sharing provisions to treatment of the illness itself. Some of those employers have discontinued that generous coverage.

Vaccine Mandates

OSHA has extended a grace period so that employers will have a bit more time to prepare to comply with the ETS. Employers had until **January 10, 2022**, to properly develop policies regarding vaccines and **February 9, 2022**, to begin to implement testing programs.

Employers should have started to prepare for the following procedures:

- Collecting employees' vaccination status
- Drafting an ETS policy
- Drafting a testing protocol
- Training employees on relevant processes and policies
- Review exemption and termination policies

On **Thursday, January 13**, the Supreme Court **rejected** the Biden Administration's Vaccine Mandate by a vote of 6-3.

The Court, however, did allow, in a 5-4 ruling, a mandate requiring health care workers at facilities that receive federal funding to be vaccinated.

Broker Compensation Disclosure

In December 2020, Congress enacted the Consolidated Appropriations Act of 2021 (CAA), which included a new requirement that bars an ERISA plan fiduciary from entering into, renewing, or extending a contract or arrangement with a "covered service provider" that is providing brokerage services or consulting services to a plan unless specific disclosures are satisfied.

- **Brokerage services:** vision, dental, recordkeeping, medical management, benefits administration, stop loss, pharmacy benefits, wellness services, transparency tools, group purchasing organization, disease management, compliance services, EAP or TPA services

- **Consulting:** related to the development or implementation of plans design, insurance or insurance selection, vision, dental, recordkeeping, medical management, benefits administration, stop loss, pharmacy benefits, wellness services, transparency tools, group purchasing organization, disease management, compliance services, EAP or TPA services

Who must disclose?

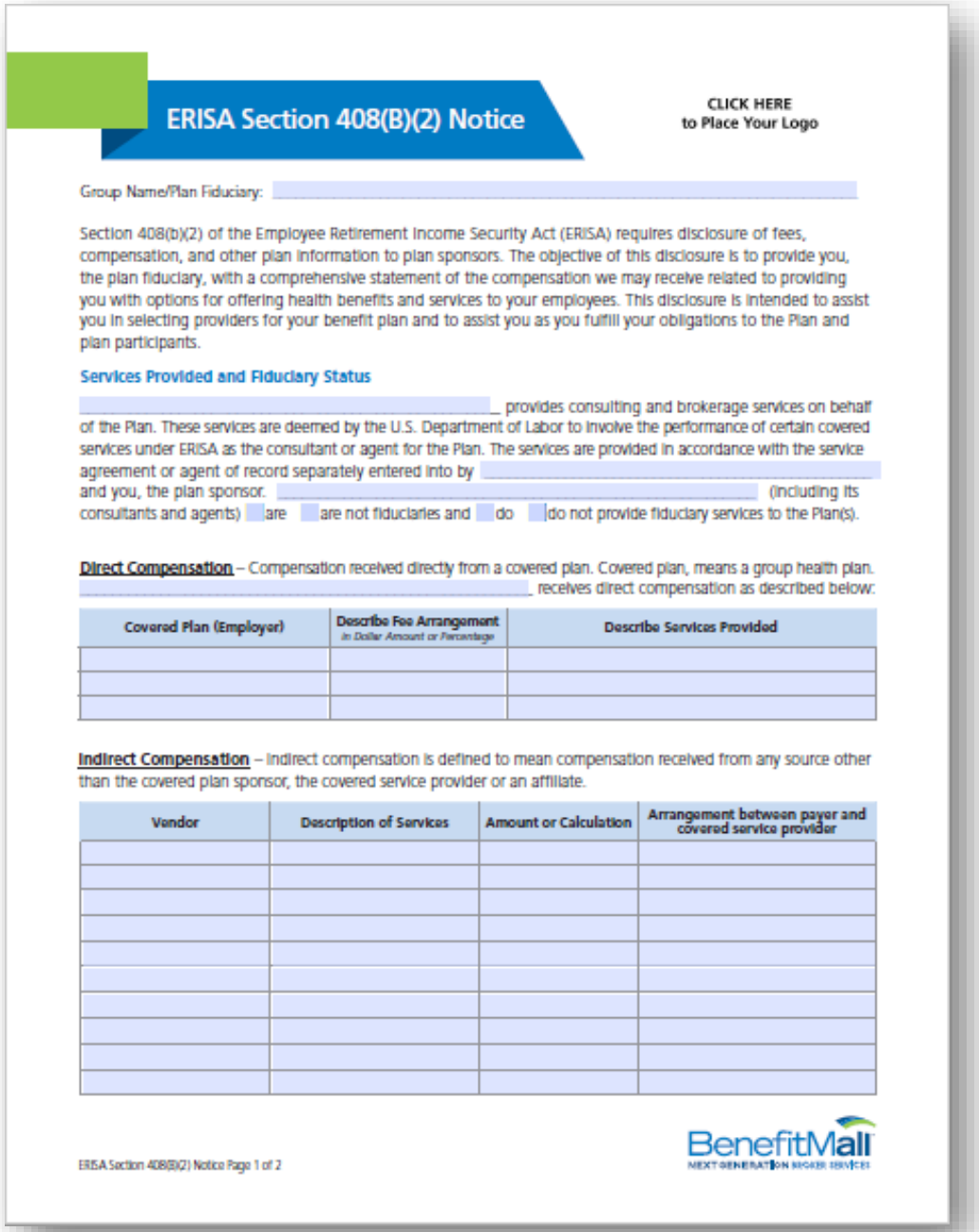
Covered service provider (brokers, agents, consultants) must disclose their commissions/fees to the employer beginning on **December 27, 2021**.

This must be disclosed **separately** from any other contract between the broker and employer.

Any renewal or new business that you write **after December 27, 2021**, **must include a disclosure** prior to "selling" the group.

The disclosure **must list all compensation** that is ***reasonably expected*** to be received by the covered service provider (brokers, agents, consultants) during the contract year.

Requirements of 408(B)(2)



ERISA Section 408(B)(2) Notice

CLICK HERE
to Place Your Logo

Group Name/Plan Fiduciary: _____

Section 408(b)(2) of the Employee Retirement Income Security Act (ERISA) requires disclosure of fees, compensation, and other plan information to plan sponsors. The objective of this disclosure is to provide you, the plan fiduciary, with a comprehensive statement of the compensation we may receive related to providing you with options for offering health benefits and services to your employees. This disclosure is intended to assist you in selecting providers for your benefit plan and to assist you as you fulfill your obligations to the Plan and plan participants.

Services Provided and Fiduciary Status

_____ provides consulting and brokerage services on behalf of the Plan. These services are deemed by the U.S. Department of Labor to involve the performance of certain covered services under ERISA as the consultant or agent for the Plan. The services are provided in accordance with the service agreement or agent of record separately entered into by _____ and you, the plan sponsor. _____ (including its consultants and agents) ☐ are ☐ are not fiduciaries and ☐ do ☐ do not provide fiduciary services to the Plan(s).

Direct Compensation – Compensation received directly from a covered plan. Covered plan, means a group health plan. _____ receives direct compensation as described below:

Covered Plan (Employer)	Describe Fee Arrangement *in Dollar Amount or Percentage*	Describe Services Provided

Indirect Compensation – Indirect compensation is defined to mean compensation received from any source other than the covered plan sponsor, the covered service provider or an affiliate.

Vendor	Description of Services	Amount or Calculation	Arrangement between payer and covered service provider

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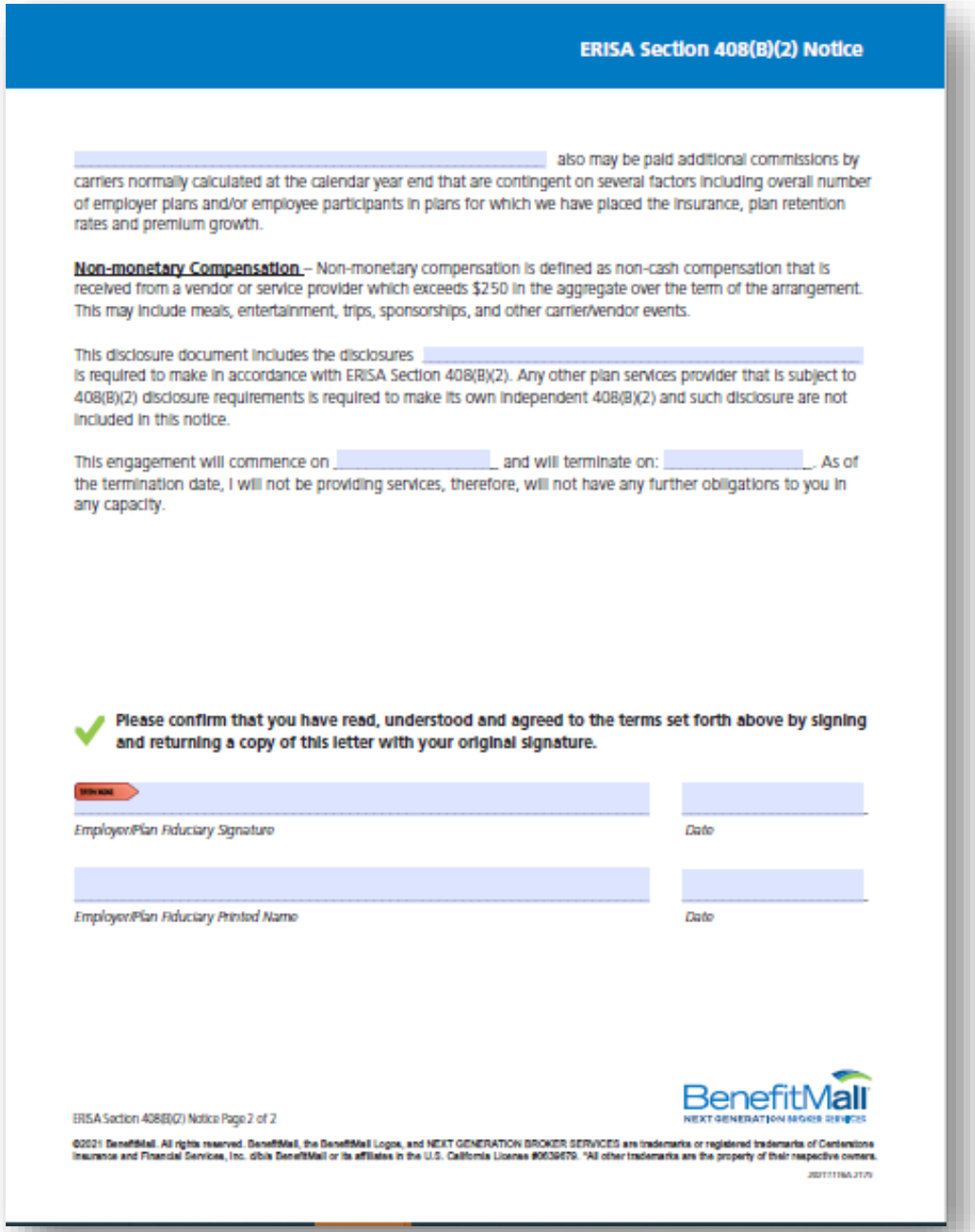
NEXT GENERATION BROKER SERVICES

ERISA Section 408(B)(2) Notice Page 1 of 2



ERISA Section 408(B)(2) Notice

_____ also may be paid additional commissions by carriers normally calculated at the calendar year end that are contingent on several factors including overall number of employer plans and/or employee participants in plans for which we have placed the insurance, plan retention rates and premium growth.

Non-monetary Compensation – Non-monetary compensation is defined as non-cash compensation that is received from a vendor or service provider which exceeds $250 in the aggregate over the term of the arrangement. This may include meals, entertainment, trips, sponsorships, and other carrier/vendor events.

This disclosure document includes the disclosures _____ is required to make in accordance with ERISA Section 408(B)(2). Any other plan services provider that is subject to 408(B)(2) disclosure requirements is required to make its own independent 408(B)(2) and such disclosure are not included in this notice.

This engagement will commence on _____ and will terminate on: _____. As of the termination date, I will not be providing services, therefore, will not have any further obligations to you in any capacity.

Please confirm that you have read, understood and agreed to the terms set forth above by signing and returning a copy of this letter with your original signature.

_____ _____
Employer/Plan Fiduciary Signature *Date*

_____ _____
Employer/Plan Fiduciary Printed Name *Date*

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NEXT GENERATION BROKER SERVICES

ERISA Section 408(B)(2) Notice Page 2 of 2

ERISA Section 408 (B)(2) Notice

Click to access browser and insert company logo

ERISA Section 408(B)(2) Notice

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Group Name/Plan Fiduciary: ABC Company

Section 408(b)(2) of the Employee Retirement Income Security Act (ERISA) requires disclosure of fees, compensation, and other plan information to plan sponsors. The objective of this disclosure is to provide you, the plan fiduciary, with a comprehensive statement of the compensation we may receive related to providing you with options for offering health benefits and services to your employees. This disclosure is intended to assist you in selecting providers for your benefit plan and to assist you as you fulfill your obligations to the Plan and plan participants.

Type your "Agency Name/Agency Associated Persons" and fields will pre-populate throughout the form

Services Provided and Fiduciary Status

XYZ Agency _ provides consulting and brokerage services on behalf of the Plan. These services are deemed by the U.S. Department of Labor to involve the performance of certain covered services under ERISA as the consultant or agent for the Plan. The services are provided in accordance with the service agreement or agent of record separately entered into by XYZ Agency and you, the plan sponsor. XYZ Agency (including its consultants and agents) ☐ are ☑ are not fiduciaries and ☐ do ☑ do not provide fiduciary services to the Plan(s).

Click appropriate boxes to select fiduciary status

ERISA Section 408 (B)(2) Notice—Front Page

Direct Compensation – Compensation received directly from a covered plan. Covered plan, means a group health plan. XYZ Agency receives direct compensation as described below:

Covered Plan (Employer)	Describe Fee Arrangement *in Dollar Amount or Percentage*	Describe Services Provided
MJB Trucking Co.	$15,000	Flat fee for RFP preparation

Indirect compensation – Indirect compensation is defined to mean compensation received from any source other than the covered plan sponsor, the covered service provider or an affiliate.

Vendor	Description of Services	Amount or Calculation	Arrangement between payer and covered service provider
Aetna	Medical	3%	Broker and medical carrier
Humana	Dental	$2.50/PEPM	Broker and dental carrier
Avesis	Vision	$1.00/PEME	Broker and vision carrier
TASC	COBRA	$.50/PEPM	COBRA vendor and broker

XYZ Agency also may be paid additional commissions by carriers normally calculated at the calendar year end that are contingent on several factors including overall number of employer plans and/or employee participants in plans for which we have placed the insurance, plan retention rates and premium growth.

Non-monetary Compensation – Non-monetary compensation is defined as non-cash compensation that is received from a vendor or service provider which exceeds $250 in the aggregate over the term of the arrangement. This may include meals, entertainment, trips, sponsorships, and other carrier/vendor events.

This disclosure document includes the disclosures XYZ Agency is required to make in accordance with ERISA Section 408(B)(2). Any other plan services provider that is subject to 408(B)(2) disclosure requirements is required to make its own independent 408(B)(2) and such disclosure are not included in this notice.

This engagement will commence on 01/01/2022 and will terminate on: 12/31/2022. As of the termination date, I will not be providing services, therefore, will not have any further obligations to you in any capacity.

Please confirm that you have read, understood and agreed to the terms set forth above by signing and returning a copy of this letter with your original signature.

Employer/Plan Fiduciary Signature *Date*

Employer/Plan Fiduciary Printed Name *Date*

Click to access drop-down calendars for all date fields

Confirm that you have read, understood and agreed to the terms, then sign and date the form using the drop-down options provided

ERISA Section 408 (B)(2) Notice—Back Page

No Surprises Act

For plan years that start on or after January 1, 2022, federal law prohibits providers from sending consumers “surprise” balance bills when an individual seeks emergency care out-of-network, or if a person receives medical care from an out-of-network provider at an in-network facility without giving their written consent.

Consumers will be protected from balance billing with regard to:

- Emergency Services
- Services provided by an out-of-network doctor at an in-network facility
- Medically necessary Air Ambulance services

Employers who self-fund their coverage will need to contract with their TPA or ASO to handle it for them. Employer plan sponsors and health insurance issuers need to notify employees about their rights.

This disclosure needs to include specific information about the federal balance billing restrictions and any applicable state laws.

Health Insurance Identification Cards

Beginning with plan years starting on or after January 1, 2022, health plan ID cards must show the following information:

- Any deductible(s)
- Out-of-pocket maximums for in-network & out-of-network
- A phone number and web address for consumers who need assistance finding in-network providers.

However, the Biden Administration will apply a “good faith” compliance standard when enforcing this requirement until they are able to finalize implementation rules.

Provider Directories

- Plan sponsors must establish a provider database on a public website that includes a list of all healthcare providers and facilities under contract.
- Plan sponsors must verify provider information in the database at least every 90 days and establish a process to remove providers when it cannot verify their information.
- Plan sponsors must update this database within two business days of receiving notification of any changes from a provider or facility.
- If a participant requests information about the network status of a provider or facility, plan sponsors must respond within one business day and retain evidence of the communication for two years.
- If a plan sponsor provides inaccurate information to a participant about the network status of a provider or facility, and the participant receives services from that provider or facility, then the participant is only responsible for paying the in-network cost-sharing amount.
- All cost sharing paid by the participant must count toward the participant's in-network deductible and out-of-pocket maximum. If the provider bills the participant more than the in-network rate, and the participant pays the bill, then the provider must reimburse the difference plus interest to the participant.

Advanced Explanation of Benefits

Effective January 1, 2022, providers and facilities must inquire whether a participant has health insurance no later than one business day after the medical appointment is made or no later than three business days after the medical appointment is made (if made at least 10 business days in advance). If the participant is insured, the provider or facility then must provide a good faith cost estimate including billing and diagnostic codes to the plan sponsor.

The plan sponsor must provide the participant with an **Advanced Explanation of Benefits (EOB)** no later than one business day after receiving the notification (if the appointment was made at least three business days in advance) or no later than three business days after receiving the notification (if the appointment was made at least 10 business days in advance). The Advanced EOB must include the following:

- The network status of each provider and facility
- If the provider or facility is in-network, the contracted rate for the services scheduled to be received
- If the provider or facility is out-of-network, the good faith estimate supplied to the plan sponsor
- The expected participant cost-sharing amount
- The estimated amount the participant has accrued toward their annual deductible and annual out-of-pocket maximum
- Any medical management requirements for procedures, such as prior authorizations
- A disclaimer that all information is estimated and is subject to change
- Plan participants can also request an Advanced EOB for services they would like to schedule. After receipt, plan sponsors have three business days to fulfill the request.

Pharmacy & Drug Cost Reporting

Effective December 27, 2021, a non-grandfathered plan sponsor must submit the following information to the Secretary of HHS, the Secretary of Labor, and Secretary of Treasury:

- Start and end dates of the plan year
- Total number of participants
- Each state where the plan or coverage is offered
- Top 50 brand prescription drugs by frequency and the total number of paid claims for each drug
- Top 50 prescription drugs by annual total spend and the total amount spent on each drug
- The 50 prescription drugs contributing to the biggest increase in plan costs compared to the prior plan year, and the total cost difference for each drug compared to the prior plan year
- Total medical and prescription drug spend broken down into various categories, including hospital costs, professional costs for primary care and specialists, prescription drugs, and more
- Average monthly premium paid, split between the employer and employee
- Any premium or out-of-pocket cost impact due to rebates or other payments by drug manufacturers. This includes reporting on rebates or other remuneration paid by drug manufacturers to the plan sponsor by therapeutic class and for each of the top 25 drugs yielding the highest rebates or other remuneration.

Mental Health Parity and Addiction Equity Act

The CAA of 2021 affected the MHPAEA of 2008 by shifting the focus to nonquantitative treatment limits (NQTLs).

Plan sponsors that offer mental health or substance abuse disorder benefits now face additional reporting and compliance requirements for NQTLs.

Of particular note is a requirement that plan sponsors complete a formal compliance analysis and make the resulting documentation available, upon request, to applicable regulators.

The Secretary of HHS or the Department of Labor may request that plan sponsors present a comparative analysis of NQTLs between mental health and substance abuse benefits and medical or surgical benefits.

Mental Health Parity and Addiction Equity Act (Cont'd)

This comparison must include:

- Specific coverage terms for NQTLs
- Factors used to determine whether a NQTL will apply to mental health or substance abuse disorder benefits and medical or surgical benefits and the evidentiary support for these factors
- An analysis demonstrating that the factors used to apply the NQTLs for mental health or substance abuse disorder benefits are comparable to and applied no more stringently than those used to apply NQTLs for medical or surgical benefits

Transparency in Coverage

Effective January 1, 2023, plan sponsors must provide the following information for 500 services specified by the DOL:

- Cost-sharing information from a particular provider or providers
- Amounts participants have accumulated toward deductibles and out-of-pocket limits
- In-network negotiated rates for covered services
- Out-of-network allowed amounts
- A list of items and services subject to bundled payment arrangements
- A notice of prerequisites, such as prior authorization required, if applicable
- Disclosure notice, including balance billing provisions, variations in actual charges, and disclosure that the estimated cost sharing is not guaranteed

Plan sponsors must make this information available to participants through a self-service tool on a public web page, and in paper form if requested by a participant.

Effective January 1, 2024:

- Plan sponsors must make the information detailed above available for all services and items.

Coverage For Covid-19 At-Home Test Kits

Health plans and insurers must cover eligible over-the-counter COVID-19 diagnostic tests, without requiring a prescription or assessment from a health care provider.

- This new guidance issued by the agencies calls for over-the-counter COVID-19 tests to be provided without participant cost, prior authorization, or medical management requirements.
- The agencies have set limits on the number of tests to be reimbursed per month, with a safe harbor of eight tests per 30-day period for each participant, beneficiary, or enrollee.
- Direct reimbursement of the seller/test provider is not required. A group health plan can require participants to submit a claim for reimbursement of the costs of the tests. The agencies however “strongly encourage” group health plans to provide direct coverage and reimburse sellers directly.
- Those that offer direct coverage will be allowed to limit reimbursement to $12 per test or the actual price of the test (whichever is lower) when a member purchases a test from a non-network pharmacy or retailer. This $12 limit helps mitigate the risk of price gouging by manufacturers and sellers.
- Health plans must continue to cover all tests prescribed by a medical provider, regardless of how the test is purchased.
- Health plans must start covering tests purchased on or after January 15, 2022.

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Employer Reporting Changes

The IRS published new rules regarding reporting standards. It directly affects 2021 reporting. The rule will automatically extend the date whereby health insurance issuers and employers need to give people their Form 1095-B and/or Form 1095-C information.

For calendar year 2021, statements will not be considered late if they are distributed on or before Wednesday, March 2, 2022.

The proposed rule also ends the “good faith” compliance standard that has been in place since 2015. It will now be much harder for ALEs to avoid significant employer shared responsibility payment (ESRP) penalties and information return penalties for completing their Forms 1094/1095 incorrectly.

So, the new mantra will be, "get it right the first time."

Build Back Better – Drug Pricing Issues
Now DEAD

- BBB amends the Social Security Act to establish the Fair Price Negotiation Program, which permits the Department of Health and Human Services ("HHS") to "negotiate" drug prices (with civil monetary penalties and the threat of a 95% excise tax for noncompliance with the Program) on certain older innovator products for Medicare Parts B and D and makes those prices available to commercial plans.
- **Inflation rebates.** Imposes mandatory drug rebates on certain Medicare Part B and Part D drugs whose prices increase greater than inflation;
- **Restructuring of Medicare Part D cost sharing.** Caps the annual out-of-pocket costs for prescription drugs at $2,000 and makes changes to the benefit structure and cost sharing under Medicare Part D.
- **Drops proposed rebate rule.** It prohibits implementation of the Trump Administration's rebate safe harbor rule, which would have ended the anti-kickback safe harbor for drug manufacturer rebates paid to Medicare Part D plan sponsors or their contracted pharmaceutical benefit managers.

Paid Leave Programs

The Biden administration is now considering a scaled-down version of a coronavirus-related paid leave program. This might be achieved as part of an omnibus spending bill.

Proponents of the program want Congress to pass provisions similar to those proposed in the HEROES Act. That legislation called for all workers to receive two weeks of COVID-related sick leave at full pay and 12 weeks of family and medical leave at two-third's pay.

The program would be temporary with an expiration date later in 2022.

The ACA & Paid Leave Reforms

The administration is looking to make the generous subsidies from 2021 a permanent fixture. Some of the other potential ACA changes include:

- Fixing the “family glitch” that ties employer plan affordability to self-only coverage.
- Narrowing the healthcare reforms states can pursue through innovation waivers.
- Creating a national paid leave program run by the federal government.
- Some are still pursuing a public option plan to compete with private insurers
- Lowering the Medicare eligibility age

COBRA Timeline Extensions

The original guidance from 2020 called for timeline extensions addressing:

- The 60-day election period for COBRA continuation coverage
- The dates for making COBRA premium payments
- The date for individuals to notify the plan of a qualifying event or determination of disability
- The date for providing a COBRA election notice for group health plans and their sponsors and administrators

In early 2021, further guidance was issued reinforcing that the timeframes were disregarded until the earlier of:

- One year from the date that individuals and plans were first eligible for relief or
- The end of the “Outbreak Period” (60 days after the announced end of the National Emergency by HHS)

COBRA Timeline Extensions (Cont'd)

IRS Notice 2021-58 was issued clarifying that individuals must make the initial COBRA election by the earlier of:

- One year and 60 days after the individual's receipt of the COBRA election notice, or
- The end of the Outbreak Period.

If an individual elected COBRA continuation coverage outside of the initial 60-day COBRA election timeframe, that individual generally will have one year and 105 days after the date the COBRA notice was provided to make the initial COBRA premium payment.

If an individual elected COBRA continuation coverage within the initial 60-day COBRA election timeframe, that individual will have one year and 45 days after the date of the COBRA election to make the initial COBRA premium payment.

What We Believe

We want to stabilize the health insurance marketplaces – nationwide.

We want to develop workable solutions to increase affordability of coverage.

We want to preserve the employer-provided group health insurance market and prevent tax increases.

Podcasts

Available on Spotify, Apple Podcasts and Amazon Music

Welcome to **BenefitMall's Compliance Café**, where we serve up a hot cup of regulatory and legislative happenings to brokers and their clients.

Sit back with your favorite cup of joe and listen to BenefitMall's compliance team discuss federal and state legislation and how it affects brokers and their clients.

BenefitMall's Compliance & Legislative Team

Questions?