Compliance Update

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Election: November 8, 2022

THE SENATE (TOSS UP)

- **Arizona Senate:** Democratic Sen. Mark Kelly has opened a lead over Republican Blake Masters.
- **Georgia Senate**: Democratic Sen. Raphael Warnock and Republican Herschel Walker are on a November collision course in the most closely divided state of the 2020 presidential election.
- **Nevada Senate**: Democratic Sen. Catherine Cortez Masto faces a tough race against Republican Adam Laxalt.
- **Pennsylvania Senate**: Republican Mehmet Oz is seeking to close a deficit with Democrat John Fetterman in the open-seat race.
- **Wisconsin Senate**: GOP Sen. Ron Johnson is running for a third term — making him the only Republican seeking reelection in a state President Biden won in 2020.
- **New Hampshire Senate:** Republicans' late primary complicates their quest to oust Democratic Sen. Maggie Hassan in the nation's smallest swing state.

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Election: November 8, 2022

THE HOUSE (LIKELY REPUBLICAN)

- **California's 27th District**: The most vulnerable GOP incumbent in the country might be Rep. Mike Garcia, whose district north of Los Angeles voted for President Joe Biden by 13 points.
- **Iowa's 3rd District**: Democratic Rep. Cindy Axne survived 2020, despite Donald Trump carrying her Des Moines-based district. But 2022 will be a steeper climb.
- **Maine's 2nd District**: House Democrats' most iconoclastic member, Rep. Jared Golden, is betting his brand of centrism can overcome a challenging political environment.
- **Michigan's 7th District**: Democratic Rep. Elissa Slotkin's battleground seat got slightly easier in redistricting, but the GOP thinks it can oust her with a national tailwind.
- **Nebraska's 2nd District**: Can a moderate Republican keep holding on to a blue-trending suburban seat? GOP Rep. Don Bacon’s race is one to watch.
- **Ohio's 1st District**:GOP Rep. Steve Chabot survived 2020, but Ohio''s new congressional map could be too steep a hill for him to climb.
- **Pennsylvania's 7th District**: Pennsylvania's new congressional map is generally good news for Democrats — except for Rep. Susan Wild, whose Lehigh Valley seat got tougher for her.
- **Texas's 15th District**: Republicans' South Texas surge could net them this congressional seat. The Rio Grande Valley swung sharply to the right in the last election.
- **Virginia's 7th District**: Democratic Rep. Abigail Spanberger is seeking a third term in a district President Joe Biden won by 6 points in 2020 but now-Gov. Glenn Youngkin flipped the following fall.

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Medical Loss Ratio (MLR) - Rebates

- **Medical Loss Ratio Search Tool**- Use the search tool to find commercial Medical Loss Ratio reports for health insurance companies offering coverage in the individual, small group, or large group market. To get started, select a reporting year and click the Search button. You may also select one or more states/territories, or enter a company name.
- The search tool only lists results for insurers that have submitted an MLR report.

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MLR - Rebates

- U.S. Department of Labor's Technical Release No. 2011-04, the employer's responsibility for distributing the rebate to participants is dependent on who paid for the insurance coverage. If the employer paid the entire cost of the insurance coverage, then no part of the rebate would be attributable to participant contributions. However, if participants paid the entire cost of the insurance coverage, then the entire amount of the rebate would be attributable to participant contributions and would be considered to be plan assets. If the participants and the employer each paid a fixed percentage of the cost, a percentage of the rebate equal to the percentage of the cost paid by participants would be attributable to participant contributions.
- The DOL guidance provides employers with the following three options for disbursing rebates:
  - To reduce subscribers' portion of the annual premium for the subsequent policy year for all subscribers covered under any group health policy offered by the plan.
  - To reduce subscribers' portion of the annual premium for the subsequent policy year for only those subscribers covered by the group health policy on which the rebate was based.
  - To provide a cash refund only to subscribers who were covered by the group health policy on which the rebate is based.

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MLR - Rebates

- These options allow for employers to distribute rebates only to subscribers (employees) who were enrolled during the year in which the rebate was paid rather than the reporting year on which the rebate was calculated. This option allows employers to avoid the burden of tracking down previous participants who may no longer be employed with the company. However, current COBRA participants must be included, as COBRA coverage must be the same coverage as available to active employees. On average, the per participant rebate will most likely be fairly small. Rather than having the administrative task of cutting relatively small checks to each participant, many employers are choosing to apply the rebate to current employee contributions, reducing the employee's payroll deduction.
- Federal tax treatment of MLR rebates paid to employees will depend on whether the employee's payroll deductions for insurance premiums were made pre- or post-tax. Employees who pay for their insurance premiums post-tax have already paid employment taxes on the deduction for insurance premiums, and the rebate will not result in any further tax liability unless the employee deducted the premium payments on his or her annual tax return. However, many employers maintain a Section 125 cafeteria plan that allows employees to pay their insurance premiums on a pre-tax basis. This means that taxes were not initially paid on the premiums and that the rebate is a return to the employee that is no longer being used to pay for health insurance premiums. Therefore, the amount of the rebate will result in an increase in taxable income subject to employment taxes. *See* IRS Medical Loss Ratio FAQs.

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1095/1094 Reporting Bills

Employer Reporting

- ***H.R. 7774, Commonsense Reporting Act of 2022***
  Reps. Mike Thompson (D-CA) and Adrian Smith (R-NE)
- ***S. 3673, Commonsense Reporting Act of 2022***
  Sens. Mark Warner (D-VA) and Rob Portman (R-OH)
- Establish a new voluntary reporting system, reduce the number of individuals and amount of information that would need to be reported, and eliminate the requirement to collect dependent social security numbers.
- Implement a suspension of enforcement during the months of the pandemic for employer-reporting provisions such as responding to 226-J letters, calculating affordability requirements for 1095 forms, and calculating ALE status with variable-hour employees.

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Medicare New Recording Requirements

- Agents and brokers will need to record all sales calls with beneficiaries in their entirety, including the enrollment process.
- **The recordings must be retained in a HIPAA-compliant manner for 10 years**.
- This will apply to new and existing clients.
- Starting Oct. 1, TPMOs will have to record all marketing calls with clients and prospects. This includes agents & brokers.

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Medicare New Recording Requirements

- CMS published a final ruling on 5/9/2022 announcing policy and regulatory revisions for Contract Year 2023. In this publication, **ONE VERY IMPORTANT CHANGE** states that field agents must record all calls with beneficiaries in their entirety, including the enrollment process. Many believe that this is in response to the barrage of deceiving TV commercials that have been airing recently. The full article from the Federal Register can be found here.
- The following is a summary of the changes published:
  - All field agents must begin recording all phone calls with beneficiaries
  - The disclaimer "I/We do not offer every plan available in your area. Please contact medicare.gov or 1-800-MEDICARE to get information on all your options" must be conveyed as follows:
    1. Verbally conveyed within the first minute of a sales phone call.
    2. Electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means of communication.
    3. Prominently displayed on third party marketing organization websites
    4. Included in any third-party marketing organization marketing materials, including print materials and television advertisements.

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Call-Recording Solutions for Medicare Advantage and Medicare Advantage Prescription Drug Plans

FREE to BenefitMall Producers*

The CMS Medicare Marketing Rule requires calls to be recorded that are part of the chain of enrollment in a Medicare Advantage or Part D plan. The chain of enrollment includes the steps taken by a beneficiary from becoming aware of a Medicare plan or plans to making an enrollment decision. The rule applies to existing and new clients.

Need a no-cost solution to the new CMS call-recording regulations?
BenefitMall has two options to help you stay compliant this AEP and streamline your sales processes at the same time!

For a limited time, the following options will be available for **FREE*** to agents that produce with BenefitMall:

- **Senior Market Sales (SMS) Lead Advantage Pro**
  If you are already using Lead Advantage Pro (LAP), then you will have an option to use the technology associated with it to initiate and receive recorded calls from virtually anywhere, whether you are on a desktop, landline, or mobile device.
- **Zoom**
  You are probably very familiar with using Zoom and have gotten used to its many capabilities. With a BenefitMall Zoom account—which we'll help you set up—Zoom will automatically record your calls. And, if you download the Zoom app, you can use your mobile device or VoIP to record and store calls.

*Some restrictions apply; no-cost offers available to agents with active policies through BenefitMall.
Ask your BenefitMall Individual and Senior Sales Team member for more details.

COBRA as Creditable Coverage

- Seniors who are enrolled in COBRA coverage but are eligible for Medicare face financial penalties for not enrolling within the mandated time-frame.
- Seniors who are enrolled in similar employer-sponsored plans are not penalized as their coverage is considered creditable for Medicare.
- Switching from a COBRA plan to Medicare could be disruptive for the beneficiary's care and may come with financial consequences for terminating their COBRA coverage early to meet the Medicare enrollment windows.
- Seniors should be able to remain on their COBRA coverage without penalty the same as seniors who remain on similar employer-sponsored coverage.

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New IRS Guidelines for 2023

FSA Contribution Levels - 2023

- For taxable years beginning in 2023, the dollar limitation under § 125(i) on voluntary employee salary reductions for contributions to health flexible spending arrangements is $3,050.
- If the cafeteria plan permits the carryover of unused amounts, the maximum carryover amount is $610.

Qualified Transportation Fringe Benefit for 2023

- For taxable years beginning in 2023, the monthly limitation under § 132(f)(2)(A) regarding the aggregate fringe benefit exclusion amount for transportation in a commuter highway vehicle and any transit pass is $300.
- The monthly limitation under § 132(f)(2)(B) regarding the fringe benefit exclusion amount for qualified parking is $300.

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Family Glitch Fix – What is the Problem?

- On Tuesday, October 11, Treasury and IRS issued final regulations amending the regulations under the Affordable Care Act regarding the affordability determination for an employee's family members of employer-sponsored health. The 2022 regulations are effective beginning with the 2023 tax year.
- Individuals are generally ineligible for premium tax credits to purchase subsidized health insurance on the Exchange if they receive an offer of affordable employer-sponsored coverage.
- Under the existing regulations from 2012 the affordability of employer-sponsored coverage for a family member is determined based on the affordability of self-only coverage, rather than the affordability of family coverage—this has come to be known as the family glitch.
- An affordable plan for PTC purposes is a plan with the employee's required contribution that is less than 9.5% of household income (indexed; this percentage will be 9.12% in 2023).
- In January 2021, President Biden issued Executive Order 14009, Strengthening Medicaid and the Affordable Care Act, which directed the Secretary of Treasury to reconsider previous regulations that limit access to affordable coverage. This was generally interpreted as opening the door to reconsideration of the family glitch.
- The 2022 Regulations fix this "glitch" by basing the affordability of employer-sponsored coverage for a family member on the cost of family coverage, rather than self-only coverage.

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Family Glitch Fix – How it Works

- Instead of basing the affordability determination for a family's employer-sponsored health insurance on just the cost to cover the employee, the determination will now be made based on the cost to cover the employee plus family members, if applicable.
- The family glitch fix will be in effect as of 2023. When families apply for 2023 coverage during the open enrollment period in the fall of 2022, the new rules will be used to determine whether anyone in the household qualifies for a premium subsidy.

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Family Glitch Fix – How it Works

- If a family has to pay more than a certain percentage of household income (9.12% in 2023) for the employer-sponsored plan, they will potentially be eligible for premium tax credits in the marketplace.
- The same would also be true if the coverage offered to the family does not provide minimum value.
- There will be a separate affordability determination for the employee (based on self-only coverage), and for family members (based on the total cost of family coverage).
- Depending on how an employer subsidizes the cost of family coverage, it's possible that coverage could be considered affordable for the employee but not for family members. In that case, the family members would potentially be eligible for a premium tax credit in the marketplace, but the employee would not.

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Family Glitch Fix – How it Works

- If a family has some members on a marketplace plan and others covered under one or more employer-sponsored plans and/or Medicare, the family's *total* premium costs could still be somewhat unaffordable.
- Premium tax credits currently ensure that households don't have to spend more than 8.5% of household income to buy the benchmark plan, but that's only applicable to the marketplace premiums.
- Premiums for other coverage are not factored in, as described here with regards to households with one spouse on Medicare and the other on a marketplace plan.

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Family Glitch Fix – How it Works

Scenario 1:

Carrie is married to John, and they file a joint tax return. John does not have access to employer-sponsored coverage, but Carrie does. Carrie's employer offers them coverage as a couple that is unaffordable based on their household income. However, the coverage would be affordable for Carrie if she joined the plan as a single individual.

Who Has Affordable Coverage?	Who Qualifies for Subsidized Individual Coverage?	Does the Employer Have Penalty Liability?
Carrie has an offer of affordable employer coverage.	*John* qualifies for subsidized coverage because he does not have an affordable offer from either his or Carrie's employer.	Carrie's employer does not. If *John's* employer is an ALE, then they are at risk of receiving a penalty for not offering him affordable employee-only coverage.

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Family Glitch Fix – How it Works

Scenario 2:

The facts of Scenario 1 remain the same, except that John gets a job at a company that offers him affordable coverage based on the single premium rate.

Who Has Affordable Coverage?	Who Qualifies for Subsidized Individual Coverage?	Does the Employer Have Penalty Liability?
Carrie and *John* now both have affordable employer offers of employee-only coverage.	Nobody.	No.

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Family Glitch

- The preamble to the final rule also explicitly states that the policy change will not impact ACA reporting for either ALEs or health insurance issuers. It remains unclear how the IRS and the health insurance exchanges will verify the cost of employer-sponsored dependent coverage or if an employee has an affordable offer of employer-sponsored coverage based on their family income.

The regulation does explain that the Biden Administration intends to:

- Revise the Exchange application on HealthCare.gov in advance of Open Enrollment for the 2023 plan year to include new questions about employer-sponsored coverage for family members;
- Revise the list of information consumers need to gather from an employer about the coverage being offered;
- Provide resources and technical assistance to State Exchanges that will need to make similar changes on their websites and Exchange application experiences;
- Provide training on the new rules to agents, brokers, and others who assist applicants so applicants will better understand their options before enrolling, including the trade-offs if applicants are considering splitting their family between exchange-based and employer-sponsored coverage; and

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Family Glitch

- If an employer's open enrollment period aligns with the annual exchange open enrollment period, then it will be simple for qualified individuals to decline group coverage and enroll in subsidized individual coverage through an exchange. However, the IRS has published Notice 2022-41 to address the complications that could arise under this final rule when an employer's plan year does not correspond with the exchange's open enrollment period.
- In most cases, individuals who enroll in an employer-sponsored medical plan can only drop their coverage midyear if they have a "qualifying event."
  - This is due to the Section 125 Cafeteria Plan regulations that allow employees to pay for medical coverage on a pre-tax basis. Right now, a spouse and/or dependent children realizing they may be eligible for subsidized exchange coverage is not a qualifying event.
  - This IRS Notice amends the existing Section 125 rules related to qualifying events so that employers with non-calendar plan years can now include this scenario as a qualifying event within their Section 125 plan documents.
  - Of note, the existing Section 125 regulations already permit employees to prospectively revoke their election for employer-sponsored coverage midyear in order to enroll in exchange-based coverage during the annual open enrollment or if they become eligible for a special enrollment period.

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Family Glitch

According to the new guidance, employers with non-calendar year plans can now allow employees to revoke their family-level (non-health FSA) medical coverage as long as:

1. At least one of their dependents wants to enroll in exchange-based coverage, either during the exchange's open enrollment period or because the dependent is eligible for a special enrollment period through the exchange.
2. And the dependent(s) intend to enroll in exchange-based coverage that starts no later than the day after their coverage under the employer-sponsored plan ends. If the employee doesn't also enroll in exchange-based coverage, they cannot revoke their own employer-sponsored coverage midyear. They, and any other individuals they're covering who don't enroll in coverage through an exchange, will need to maintain enrollment in the employer's plan.

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What Employers Need to Do

- Moving forward, employers need to be aware of the change to the affordability standard for family coverage, be prepared to communicate with employees about the new rule and be very clear about the exchange's open enrollment deadline.
- Additionally, it is more imperative than ever that ALEs ensure they are offering affordable, minimum value coverage to their full-time employees.
- While the ACA's affordability requirements under the employer mandate (and associated penalty liability) continue to only apply to the employer's lowest-cost offer of self-only, minimum value medical coverage, the existence of the new regulation means that more employees will seek exchange-based coverage. With more employees participating in the exchange, the likelihood that an ALE will receive a penalty when they fail to offer employees affordable coverage increases, too.

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Prescription Drug Data Collection (RxDC)

- Under Section 204 (of Title II, Division BB) of the Consolidated Appropriations Act, 2021 (CAA), insurance companies and employer-based health plans must submit information about prescription drugs and health care spending. This data submission is called the RxDC report. The Rx stands for prescription drug and the DC stands for data collection.
- The Centers for Medicare and Medicaid Services is collecting the RxDC report on behalf of the Departments of Health and Human Services, the Department of Labor, the Department of Treasury, and the Office of Personnel Management.
- **Resources**
  - RxDC reporting instructions (PDF)
  - RxDC templates and data dictionary (ZIP)
  - RxDC drug name and therapeutic class crosswalk (ZIP)
  - Regulation
  - Frequently Asked Questions (PDF)

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Prescription Drug Data Collection (RxDC)

What information do insurance companies and employers submit to CMS?

- The CAA requires insurance companies and employer-based health plans to submit information about:
- Spending on prescription drugs and health care services
- Prescription drugs that account for the most spending
- Drugs that are prescribed most frequently
- Prescription drug rebates from drug manufacturers
- Premiums and cost-sharing that patients pay

How will this information be used?

- The data submitted by insurance companies and employer-based health plans will help to:
- Identify major drivers of increases in prescription drug and health care spending
- Understand how prescription drug rebates impact premiums and out-of-pocket costs
- Promote transparency in prescription drug pricing

What information will be publicly released?

- We will publish findings about prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs. You will be able to download the report from this page or from the websites of the Department of Labor or the Department of the Treasury.

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BenefitMall's Compliance & Legislative Team

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Questions?

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