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Health and Welfare Plan Compliance FAQs

November 16, 2023

Presented By:

Brown & Brown Regulatory and Legislative Strategy Group

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Presentation Agenda

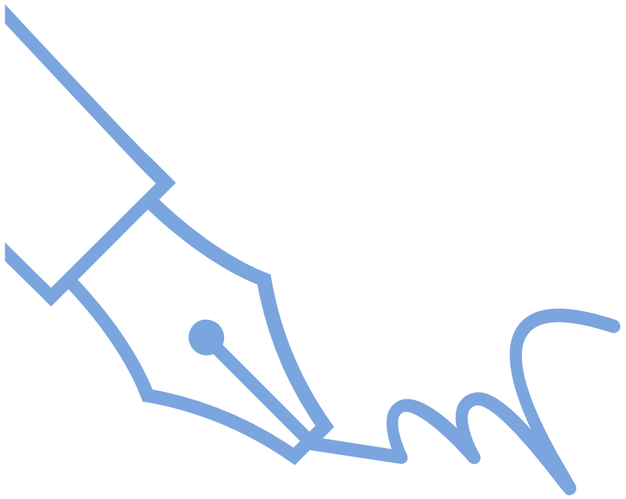
1. Does a plan sponsor need to file a gag clause prohibition compliance attestation?
2. How do telemedicine benefits impact HSA eligibility?
3. How does a Leave of Absence affect plan coverage?
4. Is economic hardship a status change event?
5. Are Employee Assistance Programs (EAPs) subject to ERISA/COBRA?
6. How does the plan sponsor comply with RxDC reporting requirements?

Does a Plan Sponsor Need to File a Gag Clause Prohibition Compliance Attestation?

Presented By:

Christopher Bao
Vice President, Regulatory
and Legislative Strategy Group

Gag Clause Prohibition Compliance Attestation



Reporting Entities are Responsible for Filing a GCPCA

A Reporting Entity must submit an attestation to CMS, attesting that they have not entered into an agreement with a provider, third-party administrator, or other service provider offering access to a network of providers that would **directly** or **indirectly** restrict a plan or issuer from providing or sharing provider-specific cost or quality of care information or data (by consumer engagement tool or any other means) or claims and encounter information.

The attestation is due to CMS by December 31, 2023, which should cover the period from December 27, 2020 through the date of the attestation.

Definition: Reporting Entity

Insurance Carriers

Fully insured carrier that sells either a group health plan or an individual policy.

Group Health Plans

(Both Fully Insured and Self-Funded)

1) ERISA Plans
2) Non-Federal Governmental Plans
3) Church Plans
4) Grandfathered/Grandmothered HP

What Coverage Is Subject to Reporting?

Fully Insured Plans that Directly/Indirectly Contract with Providers

- Create a list of all fully insured health coverage, excluding certain benefit coverage options (will go into list of benefit coverage options later, but excepted benefits such as stand-alone dental/vision/long-term care insurance are all excludable coverage options)

Self-Funded Plans that Directly/Indirectly Contract with Providers

- Create a list of all vendors/TPAs that assist you in administering the self-funded plan:
  - TPAs
  - Behavioral Health Managers
  - Pharmacy Benefit Manager(s)
  - **Exclude account-based plans (e.g., HRA, FSA) and HSA plans**

Other Benefit Options Under Group Health Plan that Directly/Indirectly Contract with Providers

- Telehealth Providers
- EAP Providers (if it does not qualify as an excepted benefit)
- Stand-Alone Wellness Programs that contract with a provider or network of providers

***This is not meant to be an exhaustive list, please speak with your legal counsel to assess the full list of vendors/carriers/TPAs that may be subject to the GCPCA obligation.**

First Question

Does the Benefit Coverage Option Contain a Health Plan Agreement with a Provider?

Group Health Plan Agreement with a Provider/TPA

Must be a contract that would **directly** or **indirectly** restrict a plan or issuer from entering into an agreement with a provider, network or association of providers, third-party administrator or other service provider offering access to a network of providers from:

1. Disclosing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to active/eligible plan participants, beneficiaries, enrollees of the plan, plan sponsors, or referring providers.

2. Electronically accessing de-identified claims and encounter information or data for each participant, beneficiary, or enrollee in the plan upon request and consistent with the privacy regulations under HIPAA/GINA/ADA, including on a per claim basis:
   - 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 or encounter transactions; or

3. Sharing information or data described above, with a business associate as defined under HIPAA, and consistent with other privacy regulations under HIPAA/GINA/ADA.

Second Question

What Benefits Are Not Subject to the GCPCA?

Account-Based Plans

- HRAs
- FSAs
- HSAs

Excepted Benefits

- Hospital Indemnity Plan
- Disease-Specific Insurance
- Stand-Alone Dental/Vision/Long-Term Care Insurance
- On-Site Clinics (but perhaps not near-site clinics)
- EAPs (Must meet certain requirements of not offering “significant medical benefits”)
- Accident-Only, Disability and Workers’ Compensation

Short-Term Limited Duration Coverage

- Insurance intended to fill a “gap” in employment between an employment termination and future employment

Third Question

Who Is Subject to the GCPCA Obligation?

Fully Insured Coverage

- Both the **fully insured carrier and the group health plan** are required to submit the GCPCA as a Reporting Entity.
  - However, if coverage under a group health plan consists of fully insured coverage and **the issuer of that coverage submits a GCPCA on behalf of the group health plan** (including non-federal governmental plans and church plans), **the Departments (i.e., Department of Labor, Health and Human Services, and the Treasury) will consider both the plan and issuer to have satisfied the attestation submission requirement**.

Self-Funded/Partially Self-Funded

- **The group health plan** is required to submit the GCPCA as a Reporting Entity.
  - Self-funded (and partially self-funded) plans may satisfy the requirement to provide an attestation by **entering into a written agreement under which the plan's service provider** (such as a Third-Party Administrator (TPA) (including an issuer acting as a TPA), **attests on its behalf**. If the plan utilizes more than one TPA, with each administering a subset of covered plan benefits, each TPA may attest on the plan's behalf with respect to the subset of benefits it administers.
  - However, if a self-funded group health plan chooses to enter into an agreement with a TPA (including sub-vendors), and a TPA (or sub-vendor) fails to submit the plan's attestation to the Departments as required, the group health plan (i.e., Reporting Entity) violates the requirement to provide an attestation of compliance.

Fully Insured: Is the Group Health Plan Responsible for the Attestation?

Fully Insured Plans

Does the remaining list of applicable fully insured plans (excluding non-applicable coverage options) have the insurance carrier attesting on GHP's behalf?

Group Health Plan

Pursuant to the instructions from CMS, a GHP obligation is satisfied if insured carrier attests on behalf of the GHP.

Analysis

1. What benefit options are fully insured coverage, where a contract exists either between the insurer or group health plan on a direct or indirect basis with a provider?
2. Is the fully insured coverage subject to the gag clause prohibition rules (e.g., excepted benefits and account-based plans are excluded from GCPCA obligation)?
3. Did the fully insured carrier attest on behalf of the GHP?
4. What remaining coverage/benefit options under the group health plan might require the group health plan to attest on its own behalf as a Reporting Entity?

Self-Insured: Is the Group Health Plan Responsible for the Attestation?

Self-Insured Plans

Does the remaining list of applicable self-insured plans have the TPAs/vendors completing the GCPCA obligation on behalf of the GHP?

Group Health Plan

Pursuant to the instructions from CMS (Centers for Medicare and Medicaid Services), a GHP must ensure that the TPA/vendors attest on behalf of the GHP.

Analysis

1. What benefit options are included in the self-funded coverage, where a contract exists between the group health plan on a direct or indirect basis with a provider?
2. Is the self-insured coverage subject to the gag clause prohibition rules (e.g., account-based plans are excluded from GCPCA obligation)?
3. Did the TPA/vendors of the self-funded plan in fact attest on behalf of the GHP?
4. What remaining coverage/benefit options under the group health plan have TPA/vendors that are unable to attest on behalf of the Reporting Entity?
5. Remaining list of applicable TPAs/PBMs/BHMs/vendors will be up to the GHP as the Reporting Entity to attest to CMS.

Other Information

The Following are Considerations for Reporting Entities

- **Multiple Health Plans (or Multiple Health Plan Numbers):** For groups with multiple health plans (or multiple ERISA plan numbers) the completion of an Excel spreadsheet evidencing each health plan may be required.

- **Plan Sponsor Is Typically the Employer:** CMS requests the EIN number of the Plan Sponsor, which is most times the employer's EIN.

- **Multiple Fully Insured Carriers Under the Health Plan:** Each fully insured carrier needs to attest on behalf of the health plan coverage for which they insure.

- **Shared Reporting:** If only some vendors attest for certain pieces of coverage, while others do not (e.g., TPA attests on behalf of the health plan, but PBM does not) then this may mean the Reporting Entity may need to attest only with respect to the non-attesting vendor (e.g., PBM).

Telemedicine and HSAs

Presented By:

Amanda Olimb
Assistant Vice President, Regulatory and Legislative Strategy Group

Annual Contribution Limits

Prorated (Monthly Maximum Contribution Method)

- The individual is eligible to contribute up to 1/12th of the applicable annual maximum for each month in the year during which the individual is HSA-eligible.

Catch-up contributions for individuals aged 55 and older by end of the tax year = $1,000.

- Annual HSA contribution limit for individuals enrolled in self-only HDHP coverage:
  - 2023: $3,850
  - 2024: $4,150
- Annual HSA contribution limit for individuals enrolled in family HDHP coverage:
  - 2023: $7,750
  - 2024: $8,300

Special Contribution Rule

"LAST MONTH RULE"

An individual may contribute the entire annual limit when first eligible for an HSA, provided they are eligible on the first day of the last month of the tax year (December 1 for most of us) and continue to be HSA-eligible throughout the entire 12 months after the last day of the last month of the applicable tax year.

- The last month rule assumes that the account holder had the same HDHP coverage for the entire year, based on coverage effective on December 1st
- If the employee is enrolled in the family tier as of December 1st of the applicable year and remains HSA eligible until December 31st of the following year, the individual is eligible to contribute up to the family maximum for the applicable year
- However, if employee joins HDHP mid-year and contributes the maximum amount to an HSA, they must remain eligible for at least 12 months after the last day of the last month of the applicable tax year (December 31st for most taxpayers), or they will be subject to taxes and penalties on the excess HSA contribution

Telemedicine and HSA Eligibility

FIRST DOLLAR COVERAGE FOR TELEMEDICINE

Background

- Availability of telehealth benefits typically makes an employee ineligible to make or receive HSA contributions

- Employers with HSA programs that also offer telehealth benefits (either through the HDHP or through a stand-alone telehealth benefit) previously needed to either:
  1. Limit the telehealth benefits available to HDHP enrollees to preventive care until the deductible is satisfied; or

  2. Charge HDHP enrollees who use telehealth services (other than for preventive care) a fee equal to the fair market value of the care until the deductible is satisfied.

- CARES Act amendment to Section 223 (March 2020)
  - » Applicable for plan years beginning before 1/1/22
  - » Coverage for “telehealth and other remote care” is disregarded when determining whether someone is eligible for HSA contributions
  - » A group health plan will not fail to be an HDHP solely because it provides coverage for “telehealth and other remote care” before the satisfaction of the minimum deductible
  - » No limit in legislation on types of care that may be received as part of “telehealth and other remote care”

First Dollar Coverage for Telemedicine

CAA of 2022

- Extended CARES Act relief
- Applies during the period of April 1 through December 31, 2022
  - » Note: Potential gap between 12/31/21 and 4/1/22

CAA of 2023

- Enacted on December 23, 2022
- Extends CARES Act and CAA of 2022 relief
- Applies during plan years starting on or after January 1, 2023, and before January 1, 2025
  - » Note: Potential gap between 12/31/22 and first day of 2023 plan year

Telehealth Expansion Act of 2023

- Proposal to permanently extend relief
- Introduced in the House and Senate 3/28/23

HSA Eligibility

Example

- Employer offers a qualifying HDHP with a plan year beginning 7/1/22 that provides first dollar coverage for telehealth for the duration of the plan year
  - » Participants would be ineligible for HSA contributions from January 2023 – June 2023 (unless they pay fair market value for telehealth services)
  - » However, if participants are HSA eligible in December (and remain HSA eligible during 2024), the full contribution rules applies
  - » If full contribution rule applies participant may contribute up to the full annual maximum for the calendar year

- Excess contributions are included in the individual's gross income and subject to 6% excise tax if not distributed (along with any earnings) from the HSA account before the tax filing deadline for the applicable year (typically April 15th of the year following the applicable tax year)

How Does a Leave of Absence Affect Plan Coverage?

Presented By:

Scott Wold
Vice President, Regulatory
and Legislative Strategy Group

Coverage During Protected Leaves

- Protected Leaves = FMLA leaves and leaves protected under comparable state laws
- Group Health Plan Coverage
  - » Employee generally has a right to continue participation as if actively working
    - ○ Employer contributions continue
  - » Employee also generally has right to discontinue coverage
  - » If employee remains enrolled in coverage, how does employee pay for coverage?
    - ○ Section 125 FMLA regulations apply if contributions were pre-tax (pre-pay, pay as you go or catch-up)

Protected Leaves

- Other benefit plan (non-health) coverage
  - » No obligation to continue coverage but participants taking FMLA leaves must be treated the same as participants taking other types of leave
  - » Eligibility will depend on the terms of the relevant plan (see discussion on next slide regarding unprotected leaves)
- For all benefits, if coverage is not continued during leave, benefits must be reinstated if employee returns to work following leave (if the employee is eligible at that time)

Coverage During Unprotected Leaves

Eligibility will depend on the terms of the relevant plan

- May vary from plan to plan
  - Could be different for medical plan vs. other plans due to Employer Mandate (i.e., employer shared responsibility penalties (ESRPs))
- Some plans specifically address eligibility during leaves; others do not
  - Eligibility could be tied to full-time status due to ESRPs (discussed later)
- Leave policy vs. terms of the plan (as reflected in plan documentation)
  - Insurance carrier obligations generally tied to terms of the plan

Leaves and ESRP Issues

- In some cases, an employee taking a leave of absence (LOA) could potentially trigger (ESRPs) if they are not offered affordable, MV coverage during the LOA
  - » Primarily an issue during unprotected leaves
- Relevance of ESRPs
  - » Apply only to ALEs (defined as an employer that averaged 50 or more FT/FTE employees in the immediately preceding calendar year)
  - » Depend on the ALE's offer of medical benefits to full-time employees (defined as employees that average 30 or more hours of service a week)
- The measurement method used by the ALE to determine whether an employee is a full-time employee is a key consideration
- Monthly measurement method (MMM)
  - » Under MMM, a FT employee generally is an employee who has 130 or more hours of service in a month
  - » Hours of service include hours not worked for which employee is entitled to payment (e.g., vacation time, PTO, sick time)
  - » If employee is receiving disability benefits, employee will have hours of service if employer makes contributions to disability plan or employee pays premiums on pre-tax basis
  - » Risk of ESRPs exists if an employee taking a leave is not offered affordable, MV coverage for any month in which they are a FT employee

Leaves and ESRP Issues

Look-Back Measurement Method

- An employee who is FT in a stability period (i.e., averaged 30 or more hours of service per week during prior measurement period) will retain FT status for the stability period despite the leave
  - Three-month rule generally does not apply to leaves
  - If medical coverage is lost, the coverage is not affordable, or the coverage is not MV, ESRP risk exists
  - COBRA qualifies as an offer of coverage, so still offering coverage for purposes of Section 4980H(a)
    - Risk exists under Section 4980H(b) if COBRA coverage is unaffordable or not MV
  - If leave spans two stability periods, status during second stability period will depend on average hours of service during measurement period and special rules apply for averaging hours when employee takes an FMLA leave, USERRA leave or jury duty leave during measurement period
- If employee is in an initial measurement period (e.g., PT, variable hour, seasonal employees), no immediate impact on ESRPs
- For new FT employees who have not completed a full standard measurement period, monthly measurement method used to determine FT status so leave could impact ESRP risk (as discussed above)

Other Issues Related to Leaves

COBRA

- Leave of absence = reduction in hours (which is a trigger event under COBRA)
- If group health plan coverage is lost due to unprotected leave, COBRA is triggered
- FMLA leave is not a qualifying event, but a qualifying event generally occurs if employee was covered under GHP prior to leave (or becomes covered during leave), employee does not return to employment at end of leave and employee has lost coverage
- Loss includes actual loss of eligibility and an increase in premiums/contributions

Voluntary Termination of Coverage

- If employee remains eligible during the leave, may they voluntarily terminate coverage?
  - » Check terms of the benefit plan to see if voluntary cancellation is allowed
  - » FMLA provides that employees generally have the right to discontinue coverage
  - » Are any employee contributions made on pre-tax or after-tax basis?
    - ○ Pre-tax contributions subject to Section 125 irrevocable election rule
    - ○ Generally pre-tax elections may be changed only when event affects eligibility
    - ○ Special Exception: Section 125 plan can allow employees who experience a reduction in hours (after which employee is reasonably expected to average <30 per week) without an attendant loss of eligibility to cancel pre-tax election for health coverage if the employee intends to enroll in a MEC plan no later than the first day of the second month after coverage is cancelled

Other Issues Related to Leaves

Return from Leave

- FMLA reinstatement requirement
- ESRP rules regarding breaks in service
  - » Impact whether employee is a continuing employee or new employee upon return
  - » If new employee, a new limited non-assessment period applies (i.e., no need to offer coverage immediately)
  - » If continuing employee and employer uses LBMM, upon return employee retains same status as prior to start of leave
  - » New or continuing status depends on length of break in service
    - ○ Break of at least 13 consecutive weeks (26 for educational organizations) → new employee
    - ○ Rule of parity
- Section 125 plan election rules
  - » Many plans have a rule under which elections are automatically reinstated if break in service is 30 days or less due to safe harbor in Section 125 regulations
    - ○ If plan includes this rule, then no election changes allowed unless independent election change event has occurred

Economic Hardship: A Status Change Event?

Presented By:

Michael Beech
Regulatory and Legislative Specialist,
Regulatory and Legislative Strategy Group

Economic Hardship – A Status Change Event?

CAN ECONOMIC HARDSHIP ALLOW AN INDIVIDUAL TO DROP PRE-TAX COVERAGE?

- "Economic hardship" is not a permitted reason to change or cancel a pre-tax election for coverage under the Section 125 Cafeteria Plan rules

- Pre-tax elections are subject to the Irrevocable Election Rule, which provides that a pre-tax election, once made, must be irrevocable for the entire period of coverage (normally the plan year) unless the individual experiences a recognized mid-year election change event (economic hardship is not one of them)

Note: If coverage is paid for on a post-tax basis, the Section 125 rules would not come into play. In that case, the terms of the underlying benefit plan would be controlling as to whether an individual can drop coverage.

Economic Hardship – A Status Change Event?

CAN ECONOMIC HARDSHIP ALLOW AN INDIVIDUAL TO DROP PRE-TAX COVERAGE?

- Mid-year Election Change Events specified in the regulations include:
  - Change in Status Events
    - Change in marital status, change in number of dependents, change in employment status of employee/spouse/dependent, change in residence, dependent ceases/satisfies dependent eligibility requirements
    - Must affect eligibility for coverage under employer's plan
  - Cost and Coverage Changes (including significant cost changes and significant curtailment of coverage)
  - HIPAA Special Enrollment Events; COBRA Qualifying Events; Judgments/Decrees/Orders
  - Change under Other Employer Plan
  - FMLA Leave; Exchange Enrollment; Reduction of Hours (without loss of eligibility); Medicare/Medicaid Entitlement

Note: If coverage is paid for on a post-tax basis, the Section 125 rules would not come into play. In that case, the terms of the underlying health plan would be controlling as to whether an individual can drop coverage.

Economic Hardship – A Status Change Event?

CAN ECONOMIC HARDSHIP ALLOW AN INDIVIDUAL TO DROP PRE-TAX COVERAGE?

- While economic hardship is not grounds for an election change under the Section 125 regulations, several of the events that permit mid-year election changes may be relevant to an employee experiencing economic hardship.

- Possibly relevant election change events to someone experiencing economic hardship include:

  - **Significant Cost Increase**
    - An individual may experience economic hardship due to a significant increase in the cost of coverage. A cafeteria plan can be drafted to allow individuals to switch to a lower cost option or drop their pre-tax election for coverage (if similar coverage is unavailable).

  - **Curtailment of Coverage**
    - An individual may experience economic hardship due to a curtailment of coverage (e.g., a significant increase in the deductible, co-pay OOP cost sharing limit). A cafeteria plan can be drafted to allow individuals to switch options in this case.

Economic Hardship – A Status Change Event?

CAN ECONOMIC HARDSHIP ALLOW AN INDIVIDUAL TO DROP PRE-TAX COVERAGE?

Possibly Relevant Election Change Events (cont):

- Reduction of Hours (without loss of eligibility due to stability period)
  - Individuals who experience a reduction in hours (<30 per week, without an attendant loss of eligibility) may experience economic hardship. If so, a cafeteria plan can be drafted to allow the pre-tax election for coverage to be dropped in this instance, if the individual intends to enroll in a MEC plan no later than the first day of the second month coverage is revoked.

- Medicaid Entitlement
  - Individuals who experience economic hardship may be Medicaid eligible (e.g., due to low income). If so, a cafeteria plan can be drafted to allow individuals to drop their pre-tax election for coverage upon Medicaid entitlement.

Note: Even if one of these mid-year election change events applies, the employer will still need to confirm that the cafeteria plan and health plan are drafted to allow individuals to drop coverage in this instance.

Are Employee Assistance Programs (EAPs) Subject to ERISA/COBRA?

Presented By:

Daniel Brady
Regulatory and Legislative Specialist,
Regulatory and Legislative Strategy Group

What Are EAPs?

EMPLOYEE ASSISTANCE PROGRAMS

EAPs are not defined under federal law and the benefits and services offered under these programs vary from employer to employer.

Examples of benefits/services/support provided through EAPs:

- Substance abuse, occupational stress, emotional distress
- Major life events: birth, accidents or death
- Healthcare concerns
- Financial or non-work-related legal issues
- Personal/family/work relationship issues

EAPs in General

- Employment-based programs
- Typically provided/managed through a third-party EAP vendor
  - » Some benefits provided through referral to qualified individuals outside EAP vendor
- Offered as stand-alone program or coordinated with employer's wellness program
  - » Life and disability carriers often include EAP as value-added benefit in conjunction with LTD policy

Most Important Factor:

Does the EAP provide medical care/benefits?

ERISA

EAPS PROVIDING MEDICAL BENEFITS

- Plan sponsor subject to ERISA + EAP provides medical benefits = EAP is employee welfare benefit plan subject to ERISA
  - Subject to ERISA's reporting and disclosure requirements, including Form 5500 reporting (unless exception applies)

- What are medical benefits?
  - "…medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services…" ERISA section 3(1)

- Does the EAP provide medical benefits?
  - DOL Advisory Opinions
    - Treatment of drug and alcohol abuse, stress, anxiety, depression and similar health and medical problems by trained professionals = medical benefits
    - Program dealing with "health problems and health-related personal problems" and "assistance in connection with problems involving mental health of employees and their dependents" = medical benefits

ERISA - Plan Documents

EAP/PLAN SPONSOR SUBJECT TO ERISA

Plan Document

- Employee welfare plans subject to ERISA must include all the benefits offered by the plan (including an EAP that provides medical benefits) within a written plan document.

Summary Plan Description (SPD)

- SPD must also be furnished to plan participants describing all the benefits included in the plan (including an EAP that provides medical benefits).

EAP Vendor Documentation

- Does material provided by third-party vendor satisfy ERISA's plan document and SPD requirements? Unlikely by themselves.

Wrap Document

- Plan sponsor may choose to include EAP within wrap plan document to satisfy ERISA's document/disclosure requirements. If EAP subject to ERISA is kept separate from wrap, the EAP will need its own ERISA plan document and SPD.

ERISA – Form 5500

EAP/PLAN SPONSOR SUBJECT TO ERISA

- If EAP treated as separate benefit (i.e., not included in single plan wrap document) a Form 5500 will be required if EAP has at least 100 participants on the first day of the plan year
  - If EAP incorporated into single bundled plan (with wrap document) = only one Form 5500 required that includes EAP as part of the many benefits offered under the plan

- Fully Insured vs. Self-Insured?
  - Schedule A required ""if any benefits under the plan are provided by an insurance company, insurance service, or other similar organization"
  - EAP typically not provided under a group insurance policy issued by an insurance carrier or similar organization (not filed with any state Insurance Department)
  - If fully insured - Schedule A required
  - If self-insured – No information related to EAP reported through Schedule A but must be reported (mark "general assets of the sponsor" on Line 9, Form 5500)
  - If unclear – Safest approach would be to request Schedule A from EAP provider

- If EAP vendor unwilling to provide necessary information for Schedule A, plan sponsor is still required to include information related to EAP within its Form 5500

COBRA

EAPS AS GROUP HEALTH PLANS

- EAP will be subject to COBRA if the EAP qualifies as a group health plan.
  - » Group health plan = employee welfare benefit plan that provides medical care

Considerations:

- Which employees are eligible for the EAP?
- Which benefits must be offered after COBRA qualifying event?
- COBRA notices
- COBRA applicable premium

COBRA – Which Employees Are Eligible for EAP?

EAP SUBJECT TO COBRA

- If EAP is offered to all employees regardless of eligibility for other group health benefits (e.g., major medical coverage) = larger population of COBRA qualified beneficiaries under EAP
  - Larger group of individuals eligible for the EAP who must be furnished with COBRA Initial Notice and Election Notice

- Note: To qualify as an excepted benefit and *not* be subject to HIPAA and the ACA, the EAP must satisfy the following four conditions:
  - The EAP does not provide significant benefits in the nature of medical care
  - The benefits under the EAP are not coordinated with benefits under another group health plan (**i.e., eligibility for the EAP must not be dependent on participation in another group health plan**)
  - Employee contributions cannot be required as a condition for EAP participation
  - The EAP must have no cost-sharing from employees for services provided under the EAP

COBRA – Which Benefits Must Be Offered?

EAP SUBJECT TO COBRA

- COBRA continuation coverage must be offered to a qualified beneficiary on the same basis as similarly situated active employees
  - » COBRA qualified beneficiary covered under EAP in class of employees **not eligible** for group health plan may be restricted to choosing either continued enrollment/disenrollment in the EAP during the annual open enrollment
    - Need not be offered other benefits under group health plan
  - » COBRA qualified beneficiary **was eligible** for medical plan in addition to EAP at time of qualifying event, they must be offered COBRA coverage for all benefits in which they were eligible for as active employee at open enrollment

- For EAPs that provide benefits outside of medical/health care (e.g., financial, job, legal counseling), COBRA need not be offered for the non-medical benefits if they can be separately offered from healthcare coverage
  - » Any non-medical benefits would be excluded when calculating applicable COBRA premium for EAP coverage

COBRA – EAP and LTD

EAP SUBJECT TO COBRA

- An EAP that provides medical care will remain subject to COBRA even when offered as a component of a benefit not subject to COBRA, such as LTD coverage

- Employers may find it difficult to get LTD carriers to provide the fair market value of the EAP component, which will be necessary when determining the applicable COBRA premium

COBRA – Alternatives for EAPs

EAP SUBJECT TO COBRA

Offering EAP Coverage Automatically

- Employer can continue EAP coverage automatically to all qualified beneficiaries for the maximum COBRA continuation coverage period (typically 18 or 36 months) following the occurrence of a qualifying event

- If EAP offered as non-COBRA benefit to employees/family after qualifying event, any increase in the cost of coverage paid by the qualified beneficiary for the EAP could be considered a loss of coverage, which could unintentionally trigger a new obligation for the employer to offer COBRA
  - » Employers that offer non-COBRA EAP coverage after an employee (or family member) experiences a qualifying event typically will not require a premium contribution from the employee (or family member)

How Does the Plan Sponsor Comply with RxDC Reporting Requirements?

Presented By:

Cindy Niesen
Associate Director of Regulatory and Legislative Strategy, Regulatory and Legislative Strategy Group

General Overview of Requirements

- Added to ERISA, Internal Revenue Code and PHSA by Consolidated Appropriations Act (CAA) of 2021
- Interim Final Regulations issued 11/23/21
    - https://www.govinfo.gov/content/pkg/FR-2021-11-23/pdf/2021-25183.pdf
- CMS published filing instructions; most recently updated in March 2023
    - https://regtap.cms.gov/reg_librarye.php?i=3860
- First report was due no later than 12/27/22 for 2020 and 2021 calendar year “reference years”
- Future reports due by June 1st of each year following the end of the reference year
    - Next report due 6/1/2024 for 2023 reference year

General Overview of Requirements

- Applies to fully insured and self-insured group health plans, but:
  - Does not apply to HIPAA excepted benefits (e.g., most dental and vision plans; fixed indemnity plans; disease-specific insurance; retiree only plans)
  - Does not apply to account-based plans (e.g., HRAs and health FSAs)
- Applies to plans sponsored by private sector employers, governmental employers, and churches and conventions and associations of churches

General Overview of Requirements

Third Party (e.g., insurance carrier, TPA, PBM, etc.) Reporting:

- Regulations allow **fully insured** group health plans to shift all responsibility to carrier if carrier agrees to perform reporting pursuant to a written agreement.

- Regulations allow a third party to perform the reporting on behalf of a **self-insured** group health plan pursuant to a written agreement, but group health plan (and plan sponsor) retains ultimate responsibility if the third party fails to comply.

- Instructions indicate that **multiple reporting entities can submit reports on behalf of a group health plan** (e.g., TPA could submit data file with spending by category on file D2 while PBM could report the top 50 most costly drugs on file D4).
  - Special rule if vendors change mid-year – Multiple reporting entities can submit the same data file for different portions of the year.

- Plan sponsor could be a reporting entity if third parties do not agree to submit all data files.
  - Note: Issues may arise in this scenario due to files requiring information related to covered lives, premiums and administrative expenses (D1).

What Information Must Be Reported?

Five General Categories of Information

1. Plan List – File P2
2. Premiums and Life Years (Covered Lives) – File D1
3. Medical Spending by Category – File D2
4. Rx Cost Information – Files D3-D8
5. Narratives

Carriers, TPAs and PBMs that file on behalf of group health plans will generally aggregate data contained in Files D2-D8 by market segment and state.

File P2: Plan List (Applies to Group Health Plans)

- Must be submitted by any reporting entity that submits a file on behalf of a group health plan
- Includes various pieces of plan identifying information (e.g., plan name, plan number, plan year, plan sponsor name, etc.) and information about issuer, TPA and/or PBM
- P2 file also indicates which additional files are being included with the reporting entity's submission

Plan sponsor may need to provide some of this information to carrier/TPA/PBM if the carrier/TPA/PBM is handling the reporting.

File D1: Life Years and Premiums

Life Years

- Average number of members (employees and dependents) throughout the year
  - Instructions illustrate how to calculate

Premiums

- Earned premium or premium equivalent
- ASO and other TPA fees paid (aggregate for plan)
- Stop loss premium paid (aggregate for plan)
- Average monthly premium paid by members
- Average monthly premium paid by employer

Carrier/TPA/PBM will not have all of this information.

Plan sponsor may need to file D1 or provide information to carrier/TPA/PBM.

File D2: Spending by Category

Report data related to the reference year for claims paid or received through March 31st of the following calendar year.

Categories:

- Hospital
- Primary care
- Specialty care
- Other medical costs and services (includes information regarding wellness spending)
  - File must include “wellness services billed on a claim.”
    - Wellness services are defined as activities primarily designed to implement, promote and improve health.
    - Instructions state: “Do not include wellness services that are not covered services under a plan or policy.”
    - Instructions specifically exclude “Wellness services not billed on a claim.”
- Medical benefit drugs: Known amounts
- Medical benefit drugs: Estimated amounts

Files D3 through D8: Prescription Drug Reporting

- Top 50 Brand Drugs, Top 50 Most Costly Drugs, Top 50 Drugs by Spending Increase, Rx Totals, Rx Rebates by Therapeutic Class, Rx Rebates for the Top 25 Drugs

- Does not include Rx drugs covered under a medical benefit (so no coordination needed between PBM and TPA) to complete D3 through D8

Narrative Response

- Seven specific narratives required
  - Employer size for self-funded plans – identify whether size was determined using actual counts or estimates; if estimates, describe estimation method
  - Net payments from federal/state reinsurance or cost-sharing reduction programs
  - Drugs missing from the CMS crosswalk
  - Medical benefit drugs
  - Rx drug rebate descriptions
  - Allocation methods for Rx drug rebates
  - Impact of Rx drug rebates
- Submitted in Word or PDF format

Potential action items for plan sponsors relative to the RxDC reporting requirement

- Determine whether carrier, TPA and/or PBM will be performing reporting on behalf of the plan
  - » If so, enter into a written agreement
- If there are multiple vendors, identify which data files be transmitted by carrier/TPA and/or PBM and which (if any) data files must be transmitted by plan sponsor on behalf of the plan
  - » If carrier/TPA/PBM is not reporting for the plan, will plan sponsor complete reporting, or
  - » Will plan sponsor engage a third-party service that can transmit any outstanding RxDC data files for the plan?
- Reporting entities must submit data through the RxDC module in the Health Insurance Oversight System (HIOS)
  - » If self-reporting any of the required data files, plan sponsor needs to create a HIOS account and collect necessary data to file any missing files through HIOS
  - » The HIOS Portal User Manual provides instructions for using the RxDC module, instructions for creating an account and contact information
- If engaging a third party to transmit any file(s), plan sponsor will need to provide or facilitate provision of any required information

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