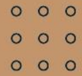

Stay compliant

Welcome to the UBA Partner Firm exclusive quarterly newsletter delivering insights about employee benefits and labor law compliance.

Benefits & Employment Briefing | Summer 2023

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Update on the End of the COVID-19 National Emergency and Public Health Emergency

In January 2023, the Biden administration announced its intent to end the COVID-19 national emergency and the COVID-19 public health emergency effective May 11, 2023, directly impacting the coverage of certain COVID-19 services as well as the timeframes for participants for certain health plan-related deadlines, such as special enrollment, COBRA election, COBRA premium payments, and claims and appeals filings.

However, on Monday, April 10, 2023, President Biden signed Congress's jointly introduced H.J Res. 7 into law, ending the COVID-19 national emergency immediately instead of on May 11, 2023, as previously announced.

The Department of Labor (DOL) has unofficially signaled that its previous guidance issued on March 29, 2023, stands, including guidance that the Outbreak Period will end on July 10, 2023.

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Employer Action Items

- Analyze whether to impose permitted cost-sharing, prior authorization or other medical management requirements for COVID-19 diagnostic tests or provide other relief suggested by the FAQ such as continued extension of applicable deadlines for claims, COBRA, and HIPAA special enrollment.
- Work with plan advisors to implement the changes to ensure that insurance carriers, including stop loss carriers, are on board with any COVID-19 enhancements the plan sponsor chooses to keep in place.
- Review plan documents and employee communications, including summary plan descriptions, to determine whether amendments are required to reflect the changes (note that language providing that the enhanced benefits only apply during the national emergency and public health emergency periods may not need to be amended).
- Immediately communicate changes in group health plan benefits and deadlines for claims, COBRA and HIPAA special enrollment resulting from the end of the national emergency and public health emergency.
- Review and update current COBRA notices to reflect the end of the Outbreak Period and work with your COBRA administrator to communicate with impacted qualified beneficiaries regarding the end of extended deadlines to make coverage elections and pay premiums.
- Understand any state or local paid leave laws related to obtaining the COVID-19 vaccine or recovering from COVID-19. Further, these state or local paid leave laws may cover caring for a family member with COVID-19. Employers should understand how any applicable state or local paid leaves intersect with their employer-sponsored health plan and COBRA coverage.
- Evaluate any COVID-19 policies, including any related to health benefits, vaccine or testing requirements, safety measures, and any other changes that may be affected by the end of the national emergency or public health emergency.

Because it is unclear whether the agencies will issue additional guidance regarding the early end of the national emergency and whether that affects the timing of the end of the Outbreak Period, employers should take the following additional steps:

- Reevaluate plan language regarding the extensions of deadlines to see if amendments are required. As noted above, the FAQs had stated that plan language providing that the extensions would automatically expire at the end of the Outbreak Period may not need to be amended. However, employers should review how the Outbreak Period was defined in their plan language as an amendment may now be required if the end of the Outbreak Period was defined as 60 days following the end of the national emergency without the caveat that it could be a different date announced by the federal agencies.

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- Work with advisors to communicate with insurance carriers and stop loss carriers regarding the use of the July 10, 2023, date as the end of the Outbreak Period to ensure there is no potential gap in coverage or question regarding the applicable deadline for HIPAA special enrollment elections, claims and appeals, and COBRA elections, and premium payments.

ACA Preventive Services: What Employers Should Know About the *Braidwood Management Inc. v. Becerra* Case

On March 30, 2023, the District Court of the Northern District of Texas (District Court) issued an opinion and order in *Braidwood Management Inc. v. Becerra* case, vacating the implementation and enforcement of certain preventive services under the Affordable Care Act (ACA), representing the most recent legal challenge against the ACA.

In *Braidwood*, the plaintiffs challenged the ACA requirement that most private health plans cover certain preventive services with no cost-sharing, claiming that this requirement is unconstitutional while the coverage of certain HIV-prevention medication violates religious rights.

On March 30, 2023, the District Court issued a ruling striking down part of the ACA's preventive care requirement (which has been recommended by the U.S. Prevention Task Force (USPSTF) on or after March 23, 2010) while also finding that the coverage of certain HIV-prevention medication did violate the plaintiff's religious rights.

However, the U.S. federal government has appealed this ruling to the U.S. 5th Circuit Court of Appeals.

What does this mean?

This District Court order *immediately* blocks the ACA's health plan requirement to cover certain preventive services recommended by the USPSTF on or after March 23, 2010, until additional guidance is issued by the 5th Circuit, and perhaps eventually, by the U.S. Supreme Court. It is not yet known if the District Court's ruling will be stayed (or blocked) while the litigation continues at the appellate court level.

On April 13, 2023, the U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra issued a press release stating that:

> The Affordable Care Act has saved the lives of millions and provided the security that our families need and depend on. Efforts to strip away access to preventive health care are harmful and unacceptable. We are seeking a stay on behalf of the millions of Americans who are able to access crucial, free preventive care like cancer screenings and cholesterol medications to prevent heart disease through the Affordable Care Act.
>
> President Biden, and this entire Administration, will do everything possible to protect and defend Americans' right to the health care they need and deserve.

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Further, the Department of Labor (DOL), the Department of the Treasury (Treasury), HHS, and the Office of Personnel Management (OPM) issued [FAQs](#) on the implementation of the ACA and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), in light of the recent court decision in *Braidwood Management Inc. v. Becerra.*

The FAQs confirm that the *Braidwood* decision only impacts "A-rating" or "B-rating" recommendations by the USPSTF on or after March 23, 2010. For example, the following preventive services fall under these USPSTF recommendations:

- Certain cancer screenings
- Alcohol and drug use
- Tobacco cessation services
- Prenatal services
- Depression screenings
- Counseling on health behaviors related to nutrition and weight management
- Preventive medications related to chronic health conditions, such as cardiovascular disease

However, not all preventive services fall under this "A" or "B" rating model. For example, the following preventive services are not impacted by the *Braidwood* decision:

- Immunizations and vaccines recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP)
- Any women's preventive services provided for in the Health Resources and Services Administration's (HRSA) guidelines (and not recommended by the USPSTF), including preventive screenings for children and contraceptive coverage requirements
- Any USPSTF "A" or "B" preventive recommendations in effect before March 23, 2010 (such as breast cancer screening, mammography, and prevention which were recommended in November 2009)

Additionally, the FAQs encourage employers to continue covering any preventive services rated either "A" or "B" by the USPSTF without cost-sharing.

How does this impact employers today?

While this case is embroiled in litigation, employers should understand if and how they are impacted by the District Court's decision while understanding the broader potential implications.

Here are points that employers should keep in mind:

- For employer-sponsored insured plans, the policy terms providing for preventive services without cost-sharing will more than likely continue until the policy is renewed.
- For employer-sponsored self-funded plans, plans may consider making a mid-year change to the plan's terms regarding preventive services. Any changes to the plan's preventive services rule will more than

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likely trigger the Summary of Benefits and Coverage (SBC) notice rule, requiring a 60-day advanced notice of changes made.

- Under the District Court's ruling, employers may still offer preventive services with no cost-sharing; however, this will be a discretionary plan design feature.
- However, before doing anything, employers may want to wait until the 5th Circuit (and eventually, perhaps, the U.S. Supreme Court) hears the case, as the District Court's opinion might be overturned or blocked during the legal proceedings.
- This ruling has a further reach: for example, ACA preventive services are treated as preventive care under the health savings account (HSA) rules. The District Court's opinion may affect which services are considered preventive care under the HSA rules.

Further, the federal government has granted certain relief for employers if they cover mental health or substance use disorders under their plan, solely to comply with the ACA's preventive services requirements. One such form of relief is avoiding certain Mental Health Parity and Addiction Equity Act (MHPAEA) requirements. It is not clear, yet, how this will be impacted if the District Court's opinion is upheld.

What's Next for Telehealth and Remote Care Services

On December 23, 2022, Congress approved the Consolidated Appropriations Act, 2023 (CAA 2023), which included a new telehealth safe harbor permitting telehealth relief for high-deductible health plans through December 31, 2024. Subsequently, the CAA 2023 was signed into law on December 29, 2022.

Not long after the passage of CAA 2023, on April 10, 2023, the Biden administration announced the immediate end of the COVID-19 national emergency, while the public health emergency ends on May 11, 2023.

With all of this legal movement, the question arises: How are employer-offered telehealth and remote care services impacted?

Background

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law, providing, in part, temporary relief to high-deductible health plans (HDHPs), allowing them to provide telehealth or other remote care services on a pre-tax deductible basis. Further, under this relief, a participant eligible for a health savings account (HSA) can receive pre-tax deductible coverage of telehealth and other remote care services from standalone telehealth vendors outside of the high-deductible health plan.

In either case, the pre-tax deductible telehealth coverage would not impact an individual's eligibility to participate in an HSA.

This CARES Act relief applied to telehealth and other remote services on or after January 1, 2020, for plan years beginning on or before December 31, 2021. This relief was originally set to expire on December 31, 2021, for

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most calendar-year plans. However, the Consolidated Appropriations Act of 2022 (CAA 2022) renewed this relief for months beginning after March 31, 2022, and before January 1, 2023, creating a three-month gap in coverage from January 1, 2022, to March 31, 2022.

The CAA 2022 relief was not tied to either the COVID-19 national emergency or public health emergency.

Effective December 29, 2023, the CAA 2023 extended telehealth coverage for another two years for plan years beginning after December 31, 2022, and before January 1, 2025, for calendar year plans.

When the public health emergency ends on May 11, 2023, standalone telehealth plan offerings must cease, effective for plan years beginning before May 11, 2023, (for example, for calendar plan years, effective Jan. 1, 2024). However, telehealth offerings on a pre-deductible basis may continue through December 31, 2024 (for calendar year plans).

Additionally, effective May 12, 2023, full enforcement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) resumes, and any employers offering telehealth remote communications (such as Zoom, Skype, or Facebook Messenger) must resume full HIPAA compliance on August 10, 2023. Group health plans should review their internal processes, along with their business associates, to determine which processes may not comply with HIPAA moving forward.

Employer Actions

Employers who sponsor qualified high-deductible health plans with pre-tax deductible telehealth coverage will enjoy relief for plan years beginning after December 31, 2022, and before January 1, 2025. For plan years beginning on or after January 1, 2025, certain telehealth offerings may impact an employee's HSA eligibility if no further relief or guidance is provided.

For plans offering standalone telehealth services, this relief is available until the end of the latest plan year beginning on or before the last day of the public health emergency. For example, this relief would expire on December 31, 2023, for calendar plan years. Once this relief ends, the employer may need to provide plan participants a 60-day notice of a material reduction in benefits, as required by the Affordable Care Act.

For any employers that made plan design changes anticipating the earlier end of this temporary relief may want to discuss plan updates with their carrier or third-party administrator.

Employers should continue to watch for any legislative or agency updates on telehealth or other remote care services, as multiple bills have been proposed in Congress to further extend or make permanent telehealth relief.

HHS Releases New Reporting Instructions Ahead of the Drug Data Collection (RxDC) Deadline on June 1, 2023

Under Section 204 of the Consolidated Appropriations Act, 2021 (CAA) (referred to as "The No Surprises Act"), all employer-sponsored health plans must satisfy certain transparency requirements by reporting annual

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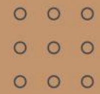

prescription drug and health care spending data, often referred to as the "Prescription Drug Data Collection (RxDC) report."

Specifically, this RxDC requirement applies to all employer-sponsored health plans as well as health insurance providers in both the individual and group markets. Account-based health plans (such as health reimbursement accounts) and excepted benefits (such as dental or vision coverage) are exempt for the RxDC requirement.

This RxDC data is reported to the Department of Labor (DOL), the Department of the Treasury (Treasury), and the Department of Health and Human Services (HHS) (collectively, "the "Departments") on an annual basis.

Initially, the RxDC report covering 2020 and 2021 data was due by December 27, 2022; however, the Departments provided a grace period for submissions through January 31, 2023. If employers make a good faith submission on or before January 31, 2023, the Departments considered the plan or provider to be compliant.

On March 3, 2023, HHS released new instructions for employers and providers, providing step-by-step guidance on how to submit RxDC reports through the Health Insurance Oversight System (HIOS). These new instructions also clarify who should report and when, helping employers better understand their responsibilities under these new transparency laws.

Further, HHS's new instructions include explanations of spending categories and data aggregation rules, while now permitting multiple vendors to report RxDC data files on behalf of an employer.

Finally, the new instructions address suspended data aggregation restrictions while providing additional guidance on prescription drug rebate reports.

Failure to comply with the RxDC reporting requirements falls under Internal Revenue Code Section 4980D penalties, resulting in a $100 per day fine for each day of non-compliance.

Employer Action Items

- The next annual RxDC reporting is due by June 1, reporting data from the previous calendar year (no matter of the health plan's plan year). So, on June 1, 2023, RxDC reporting will cover 2022 data. For the June 1, 2023, due date, employers will *not* be able to rely on any extensions or good faith effort arguments.
- For fully insured health plans, the insurance carrier is responsible for timely filing of the RxDC report. Even though employers are not directly responsible for filing the RxDC report, they should follow up with their insurance carrier, confirming that the report has been timely filed while requesting a copy of the documentation for their plan records.
- For self-insured health plans (including level-funded plans), the employer is responsible for timely filing of the RxDC report. However, most employers will rely on their third-party administrator (TPA), pharmacy benefits manager (PBM), or administrative services only providers (ASOs) to submit the report, which is expressly permitted by the regulations. Like insured health plans, employers should follow up with their TPA, PBM, or ASO, confirming that the report has been timely filed while requesting a copy of the documentation for their plan records.

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- If an employer has a third party submitting the RxDC reporting on its behalf, employers must still timely provide any requested information to their insurance carrier, TPA, PBM, or ASO.

DOL Cybersecurity Guidance: What Employers Need to Know for their Health and Welfare Plans

The Employee Benefits Security Administration (EBSA) and the Department of Labor (DOL) continue their efforts in both civil and criminal investigations of employee benefits plans focusing on plan sponsors' fiduciary duties. Employers with health and welfare plans must remember that one fiduciary duty of particular interest is the obligation to manage cybersecurity risks to their employer-sponsored plans.

In April 2021, the DOL issued cybersecurity guidance – the first of its kind – for health and welfare plan sponsors. The DOL's cybersecurity guidance was released in three parts:

1. Tips for Hiring a Service Provider with Strong Cybersecurity Practices, which provides guidance to plan fiduciaries in the hiring of service providers
2. Cybersecurity Program Best Practices, which provides best practices for recordkeepers and other service providers
3. Online Security Tips, which provides advice to plan participants and beneficiaries who check and manage their accounts online

While this guidance may not explicitly refer to employer-sponsored plans other than ERISA-governed retirement plans, plan fiduciaries should consider the tips and best practices for other employer-sponsored plans, to the extent applicable. This is particularly true for other plans governed by ERISA, such as health and welfare plans, because the same fiduciary responsibilities applicable to retirement plans would apply to health and welfare plans as well.

Since this initial guidance was issued, the DOL has begun an initiative to audit ERISA plans' cybersecurity programs. When conducting these audits, the DOL has requested detailed documentation on all cybersecurity and information security programs relating to an employer's health and welfare plan, including proof of cybersecurity training, reports of any past breaches, and documentation on service providers' security programs.

Tips for Hiring a Service Provider

Sponsors of ERISA-sponsored plans are no strangers to hiring service providers to work with their health and plans and are familiar with the requirement to ensure a prudent process for the selection and monitoring of such service providers. This guidance now sweeps cybersecurity considerations into the topics of consideration when selecting service providers.

The DOL provides suggested questions to ask potential service providers to gauge a service provider's cybersecurity practices. This includes asking the service provider about its information security standards, audit policies and results, how it validates its practices, what levels of security standards it has met and implemented,

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and past security breaches. The responses should be considered against other potential service providers, industry standards, and the service provider's track record.

The DOL guidance also suggests careful attention to the service contract. Under this DOL guidance, the service contracts should, among other things:

- Require the service provider to obtain third-party audits on an annual basis.
- Identify how quickly a service provider must inform plan fiduciaries of breaches.
- Specify the service provider's obligation to meet applicable federal, state, and local laws regarding privacy, confidentiality, or security of participants' personal information.

Cybersecurity Program Best Practices

The DOL has identified a 12-point best practice system for use by recordkeepers for plan-related IT systems and for use by plan fiduciaries in making prudent decisions regarding cybersecurity measures. In brief, the DOL recommends that plan fiduciaries:

1. Have a formal, well-documented cybersecurity program.
2. Create a prudent, annual risk assessment program.
3. Engage a third-party annual audit of the security controls.
4. Clearly define and assign information security roles and responsibilities.
5. Ensure strong access control procedures.
6. Assess third-party service provider use of cloud computing.
7. Conduct annual cybersecurity awareness training.
8. Implement a secure system development life cycle (SDLC) program.
9. Implement a business resiliency program to address business continuity, disaster recovery, and incident response.
10. Encrypt sensitive data.
11. Implement strong technical controls to implement best security practices.
12. Be responsive to cybersecurity incidents or breaches.

Moving Forward with the DOL Guidance

Cybersecurity has been an increasing concern across the board as processes and platforms have increasingly moved to remote or electronic providers. Given this landscape of electronic services and the DOL's recent guidance, plan fiduciaries should review and analyze their processes currently in place to address cybersecurity risks. Having a strong cybersecurity policy in place that follows the DOL guidelines will ensure plan fiduciaries are able to fulfill their obligations when it comes to cybersecurity concerns and prevent DOL penalties on audit.

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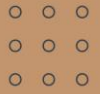

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