
# Compliance Recap | July 2023

Aug. 5, 2023

July saw two proposed rules, one focusing on short-term, limited-duration health plans, and one addressing provider networks and data collection for the Mental Health Parity and Addiction Equity Act (MHPAEA). The PCORI fee was due on July 31 for plan sponsors of self-insured groups and HRAs. President Biden encourages group health plan sponsors to extend the open enrollment period for employees coming off Medicaid and CHIP.

## Proposed Changes to Short-Term, Limited-Duration Insurance

On July 7, 2023, the U.S. Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury proposed changes to modify the definition of short-term, limited-duration insurance (STLDI) and the conditions for fixed indemnity insurance to be considered an excepted benefit. The proposal also asks for comments on specified disease plans and level-funded plans. The proposal looks to clarify the tax treatment of certain benefit payments under group health plans.

Short-term, limited-duration insurance is meant to fill temporary gaps in coverage during transitions. The proposal suggests limiting the initial contract period to no more than three months and the maximum coverage period to no more than four months, including renewals. This change aims to differentiate STLDI from comprehensive coverage and reduce financial risk for individuals using it as a long-term alternative.

The proposal also forbids the same issuer from issuing multiple STLDI policies to the same policyholder within a year (known as "stacking"). STLDI sales mainly occur through group trusts or associations, and the proposal clarifies that such sales are not group coverage for federal law purposes.

Fixed indemnity plans provide income replacement rather than full medical coverage. The proposed regulations look to clarify that this coverage should not pay benefits on a per-service basis, to avoid mimicking comprehensive coverage without providing the same consumer protections. The proposal also includes payment standards for fixed indemnity plans and clarifies that such coverage must be offered independently without coordination with other health plans.

Consumer notices would provide clearer information on the differences between STLDI, fixed indemnity excepted benefits coverage, and comprehensive coverage.

## PCORI Fee Payment

Plan sponsors of self-funded medical plans, including health reimbursement arrangements (HRAs), were required to report and pay fees to the Patient-Centered Outcomes Research Institute (PCORI) by July 31. This fee on group health plans was created through the 2010 Patient Protection and Affordable Care Act (ACA).

Research funded by PCORI concentrates on healthcare challenges faced by families every day, including cancer, diabetes, maternal mortality, opioid addiction, mental health, and equitable access to care, among many others.

If you believe you should have paid this fee, contact your broker for information, and access additional information including Form 720 for to submit the fee.

## Group Health Plans Encouraged to Expand Enrollment Period for Individuals Losing Medicaid and CHIP

In a letter dated July 20, 2023, from the Center for Medicare and Medicaid Services (CMS) to employers, plan sponsors, and issuers, the Biden Administration encouraged these entities to offer additional enrollment opportunities in group health plans for employees and their dependents who are losing coverage under Medicaid.

The U.S. is experiencing a health coverage transition due to the COVID-19 pandemic. The pause on Medicaid coverage verifications and terminations ended on March 31, 2023, and state Medicaid agencies are now resuming regular eligibility and enrollment operations, which include renewing coverage for eligible individuals and terminating coverage for those no longer eligible.

According to a Department of Health & Human Services report, about 3.8 million individuals who lose Medicaid eligibility could be eligible for employment-based coverage. The Administration believes that many people may need more than the typical 60-day window after losing Medicaid or Children's Health Insurance Program (CHIP) coverage to apply for and enroll in other coverage, especially considering the unique circumstances surrounding the resumption of Medicaid and CHIP renewals.

To address this concern, CMS has announced a temporary special enrollment period on HealthCare.gov. Marketplace-eligible individuals who lose Medicaid or CHIP coverage and come to HealthCare.gov between March 31, 2023, and July 31, 2024, will be able to enroll. Employers are encouraged to follow suit by expanding special enrollment periods for individuals losing Medicaid or CHIP coverage. These changes would require a plan amendment and approval from the insurance carrier.

Employers interested in sharing this with employees should provide information about Medicaid and CHIP renewals to employees and encourage them to update their contact information with their state agency, using CMS resources available at www.medicaid.gov/unwinding. Employers can voluntarily open enrollment in their employment-based plan for those losing Medicaid or CHIP coverage.

## Proposed Rules May Impact MHPAEA and NQTL Data Collection

On July 25, 2023, the U.S. Departments of Treasury, Labor, and Health and Human Services (the "Departments") issued a comprehensive set of guidelines to help employers comply with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). The guidelines, including definitions and examples, emphasize the importance of access to mental health and substance abuse treatment, and data collection for the production of analysis reports.

A new rule focuses on networks having an adequate number of appropriate providers. Low reimbursement rates for behavioral health care providers compared to primary care providers negatively impact access to care. Plans must collect and analyze network adequacy data and provider reimbursement rates to address this issue.

The guidelines also establish specific content and delivery requirements for the non-quantitative treatment limitations (NQTL) comparative analysis and set minimum data collection standards. The Departments expressed dissatisfaction with the current state of plans compliance with the NQTL analysis requirements and aim to bridge the gap with the proposed regulations.

These regulations are still in the proposal stage, and incoming comments may lead to modifications. Employers should review the guidelines with their brokers, paying particular attention to their network providers, as access to mental health and substance abuse disorder care is a top priority.

## Question of the Month

**Q.** My staff count has been fluctuating around 50 for some time. How do I know if or when I need to offer health insurance to my employees?

**A.** Whether an employer is an applicable large employer (ALE) is determined each calendar year, and generally depends on the average size of an employer's workforce during the prior year.

If an employer has fewer than 50 full-time employees, including full-time equivalent employees, on average during the prior year, the employer is not an ALE for the current calendar year and therefore not subject to the employer shared responsibility provisions or the reporting provisions for the current year.

If an employer has at least 50 full-time employees, including full-time equivalent employees, on average during the prior year, the employer is an ALE for the current calendar year, and is therefore subject to the employer shared responsibility provisions and the reporting provisions.