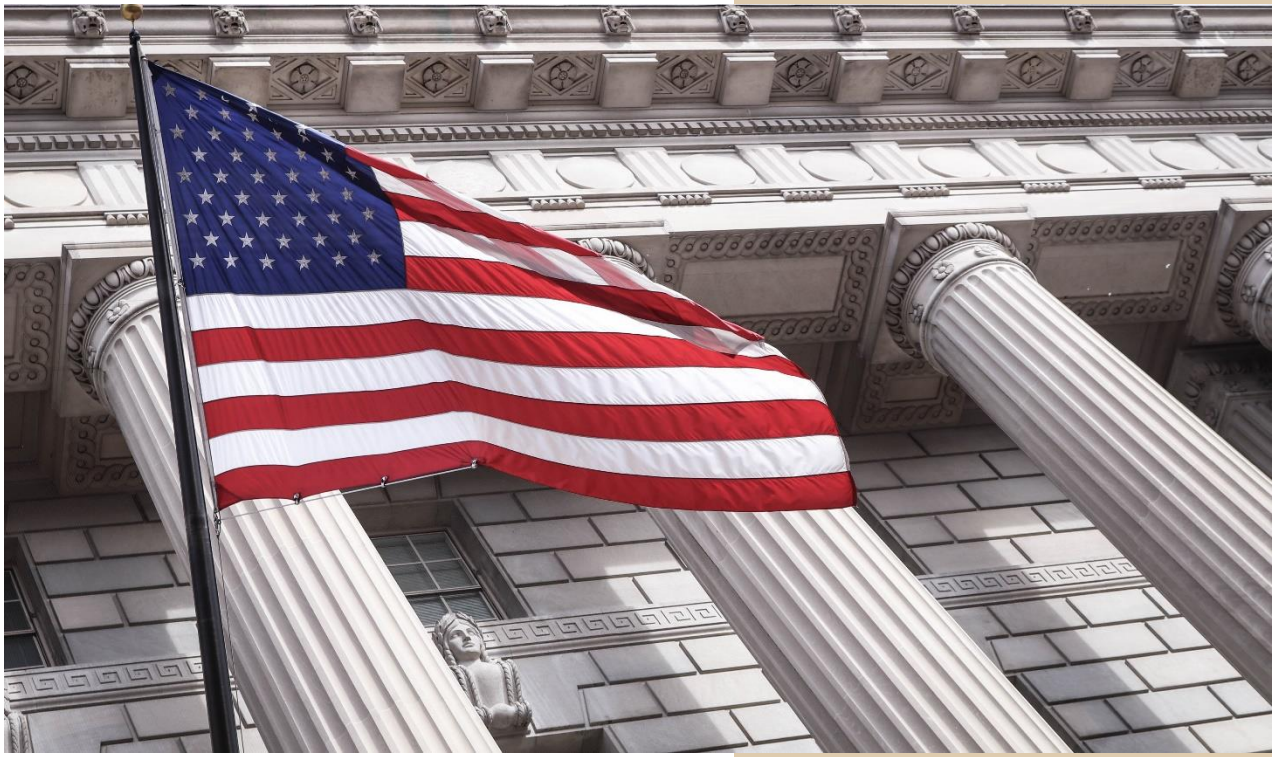
Employee Benefits Compliance Briefing

Winter 2023



Stay Compliant

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

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Acadia BENEFITS

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About UBA

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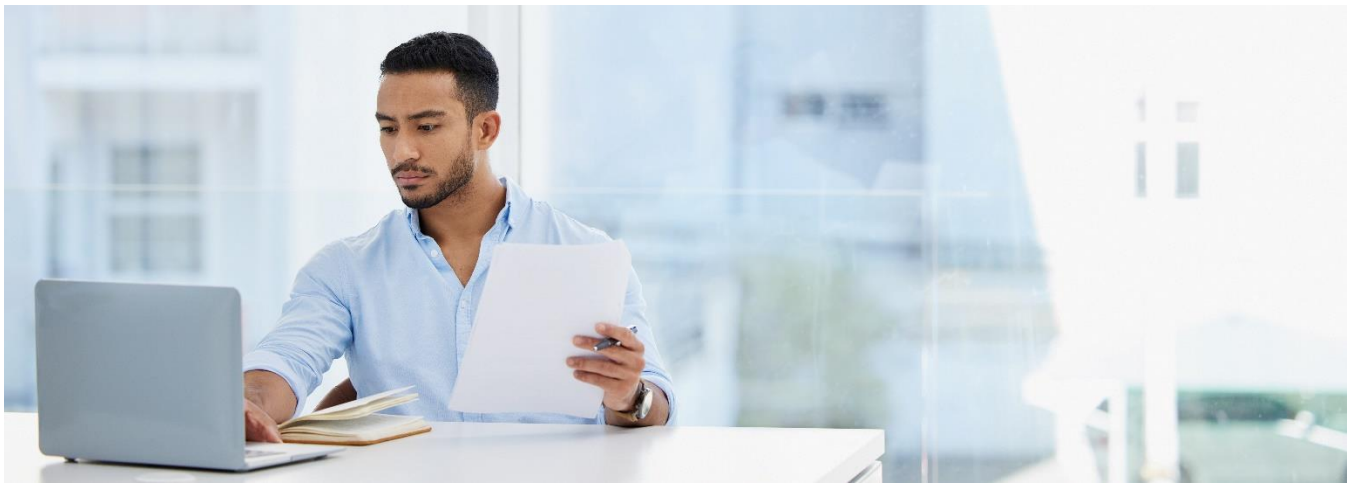


First Gag Clause Attestations for Health Plans Due December 31, 2023

The Consolidated Appropriations Act, 2021 (CAA) prevents group health plans and issuers from entering into agreements with health care providers, third-party administrators (TPAs), and other service providers with gag clauses that restrict or prohibit the amount of information shared with plan participants, beneficiaries, plan sponsors, and other providers.

Annually, health plans and issuers must attest to the Departments of Labor (DOL), Human and Health Services (HHS), and Treasury (the "Departments") that they comply with the CAA's prohibition on gag clauses.

The first gag clause attestation is due December 31, 2023, covering the period from December 27, 2020 (the day the CAA was passed), through the attestation's date.

Subsequent attestations will be due by December 31 each year, covering the period between the last attestation and the current one.

Which Plans Should Attest?

This gag clause attestation requirement applies to:

- Group health plans (both ERISA-governed and non-ERISA-governed, such as church plans)
- Individual health plan coverage
- Plans meeting the qualifications for ACA grandfathered or grandmothered plans

However, this attestation requirement does *not* apply to excepted benefits or account-based plans, such as health reimbursement arrangements (HRAs).

How to Submit an Attestation

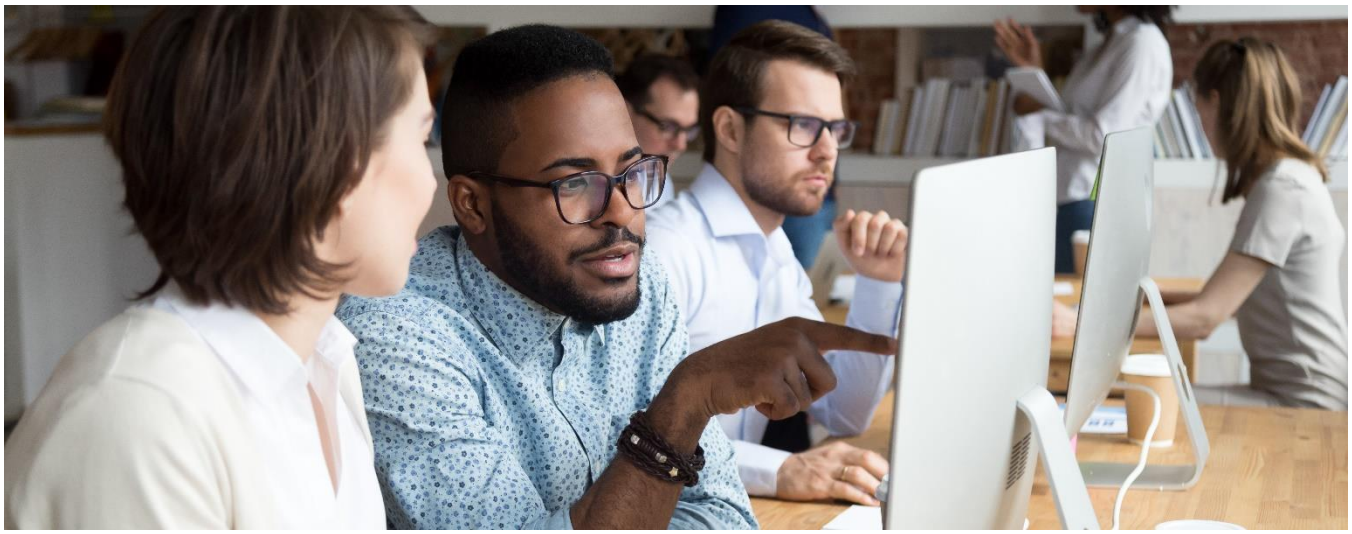
According to recently issued DOL FAQ guidance, gag clause attestations must be electronically submitted on the Centers for Medicare & Medicaid Services (CMS) website. The Departments have provided instructions for filing these attestations and answers to frequently answered questions to help health plan sponsors through this reporting process.

For fully insured group health plans, the health plan and the issuer must submit the gag clause attestation annually. However, if the issuer submits the attestation on behalf of the group health plan, the Departments will consider the group health plan to have satisfied this attestation requirement.

For self-insured group health plans, the plan sponsor is legally responsible for filing the gag clause attestation annually. These employers can enter into an agreement with their TPA or other service provider to have the TPA submit the attestation. However, even if this obligation is contracted, the legal responsibility for filing the attestation remains with the health plan.

Next Steps for Employers

- Employers should review their written agreements with their plan issuers, TPAS, and other service providers, ensuring that the agreements do not contain any prohibited gag clause language.
- Employers may need to update their service provider agreements to identify which entity shall file the annual attestation (keeping in mind that no matter the contract language, the legal responsibility for filing the attestation remains with the self-insured health plan).
- Employers who must submit their own gag clause attestation should review the instructions for doing so while keeping records of proof of filing.



New FAQs Released on the No Surprises Act After the *Texas Medical Association vs. HHS* Decision

On October 6, 2023, the Departments of Labor, Treasury, and Health and Human Services (the "Departments"), along with the Office of Personal Management (OPM), released frequently asked questions (FAQs) on the No Surprises Act (NSA).

These newly issued FAQs follow the recent Texas federal district court decision in *Texas Medical Association et al. v. United States Department of Health and Human Services et al.* (TMA III) (August 24, 2023), which is one of the latest legal disputes involving the NSA's implementation.

The TMA Decision

Under the NSA, qualifying payment amounts (QPAs) represent the median contracted rates for a specific service, adjusted for the market consumer price index for that geographic area.

The QPA helps determine patient cost-sharing for specific out-of-network services. It also serves as a factor in the independent dispute resolution (IDR) process for determining the appropriate payment amounts.

Under the July 2021 interim final rules, the Departments established a calculation methodology for health plans to determine the QPA. However, many healthcare provider groups disagreed with the calculation, claiming that it could yield low amounts not in line with market rates.

TMA III challenged this calculation methodology, resulting in a court ruling that vacated many components of the calculation methodology, including:

- Using rates for services that a particular healthcare provider did not provide
- Allowing self-insured plans to use similar rates as other self-insured plans (and administered by the same third-party administrator)
- Excluding single case agreements

- Using rates for healthcare providers in the same or similar specialty
- Excluding incentive, bonus, and risk-sharing payments

The TMA III ruling left QPA methodology calculations in a state of uncertainty while causing the Departments to shut down the IDR portal on August 25, 2023, to make the necessary changes to comply with the court order.

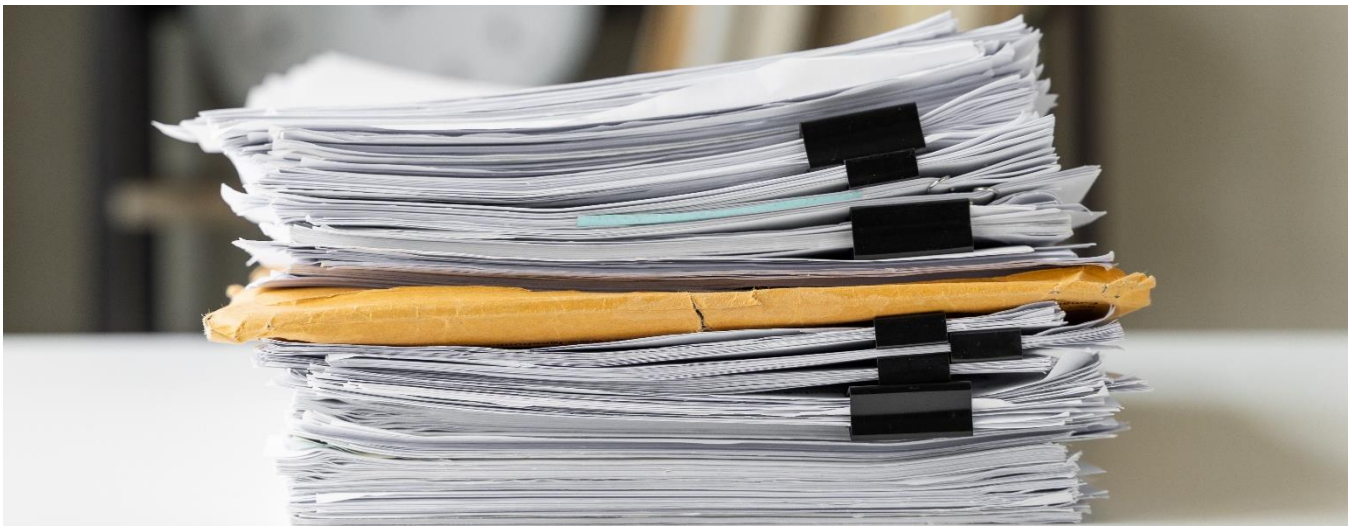
New NSA FAQs

Under the newly released FAQs, which clarify the NSA in light of the TMA III ruling, the Departments have:

- Acknowledged that TMA III is current law, although they plan to appeal the district court decision.
- Re-opened the IDR portal for single and bundled pricing disputes. Batched disputes remain suspended until the Departments update relevant guidance. For clarification, bundled disputes include multiple services bundled into one claim where batched dispute includes multiple claims batched into one dispute.
- Instructed health plans to use a good faith, reasonable interpretation of the statutes and regulations remaining in place after the TMA III ruling.
- Announced that they will exercise "enforcement discretion" for payment disputes using the QPA calculation methodology under the July 2021 interim final rules for any items or services provided before May 1, 2024 (the date that the Departments will begin enforcing the TMA III ruling).

Next Steps for Employers

Although medical providers, facilities, certified IDR entities, and third-party administrators primarily focus on QPAs and IDRs, employers should still connect with their third-party or claims administrators, confirming that providers, services, and claims are treated properly under the No Surprises Act.



HHS Announces Civil Penalties for HIPAA, ACA, and MSP Violations

On October 6, 2023, the Department of Health and Human Services (HHS) released inflation-related penalty adjustments for violations of the Health Insurance Portability and Accountability Act (HIPAA), Affordable Care Act (ACA), and the Medicare Secondary Payer (MSP) rules.

These adjusted amounts apply to penalties assessed on or after October 6, 2023, for any violations occurring on or after November 2, 2015.

Health Insurance Portability and Accountability Act (HIPAA)

The penalty amounts related to the HIPAA privacy and security rules are broken down into a four-tiered structure based on the violator's intention level.

Violation	New 2023 Penalty Amounts	2022 Penalty Amounts
TIER 1 Violation of HIPAA rules due to lack of knowledge	$137 minimum $68,928 maximum $2,067,813 calendar year cap	$127 minimum $63,973 maximum $1,919,173 calendar year cap
TIER 2 Violation of HIPAA rules due to reasonable cause and not willful neglect	$1,379 minimum $68,928 maximum $2,067,813 calendar year cap	$1,280 minimum $63,973 maximum $1,919,173 calendar year cap
TIER 3 Violation of HIPAA rules due to willful neglect and corrected within 30-day period	$13,785 minimum $68,928 maximum $2,067,813 calendar year cap	$12,794 minimum $63,973 maximum $1,919,173 calendar year cap
TIER 4 Violation of HIPAA rules due to willful neglect and **not** corrected within 30-day period	$68,928 minimum $2,067,813 maximum $2,067,813 calendar year cap	$63,973 minimum $1,919,173 maximum $1,919,173 calendar year cap

ACA: Summary of Benefits and Coverage (SBC)

The ACA requires plan sponsors and insurers to provide SBCs to eligible employees and their beneficiaries before enrollment (or re-enrollment) in a group health plan. The maximum penalty for failing to provide an SBC to covered individuals increases to $1,362 (from $1,264).

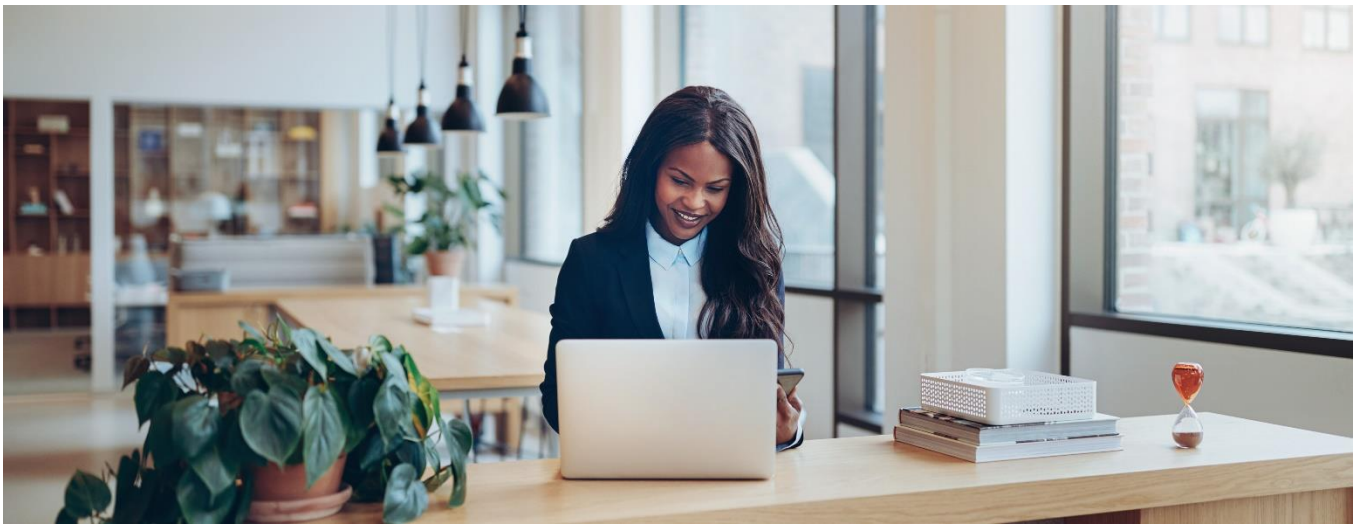
Medicare Secondary Payer (MSP)

The MSP rules prohibit employers and insurers from offering Medicare beneficiaries financial or other incentives that encourage these beneficiaries to waive or terminate group health plan coverage that would be primary to Medicare.

The maximum penalty for failing to comply with these MSP rules increased to $11,162 (from $10,360). Additionally, the maximum penalty for failing to inform HHS when a group health plan is or was primary to Medicare increased to $1,428 (from $1,325).

What Employers Should Do Next

To avoid these penalties, employers should review their plan documents and operations, ensuring compliance with the above HHS-related requirements.



New PCORI Fee Announced by IRS

The Internal Revenue Service (IRS) recently released the adjusted Patient-Centered Outcomes Research Institute (PCORI) fee rate for policy and plan years ending on or after October 1, 2023, and before October 1, 2024.

Background

The Affordable Care Act (ACA) imposed a fee on issuers of fully insured plans and plan sponsors of self-insured plans. These assessed fees are contributed to the Patient-Centered Outcomes Research Trust Fund, which funds research, such as:

- Health outcomes and risks
- Clinical effectiveness
- Medical treatments and procedures
- Strategies to diagnose, treat, manage, and prevent injury or illness

The previously announced fee for policy or plan years ending on or after October 1, 2022, and before October 1, 2023, was $3.00 per covered life per year. The PCORI fee is currently scheduled to expire in 2029 or 2030, depending on the policy or plan year.

For more information on the PCORI fee, see the IRS questions and answers.

Updated PCORI Fee

For policy or plan years ending on or after October 1, 2023, and before October 1, 2024, the PCORI fee is now $3.22 per covered life. Issuers of fully insured health plans and employers who sponsor self-insured group health plans, including health reimbursement arrangements (HRAs) and level-funded health plans must pay this fee by July 31, 2024.

Plan sponsors of self-insured group health plans must pay this fee using IRS Form 720. According to Internal Revenue Code Section 162, the PCORI fee is tax deductible for the plan sponsor as an ordinary and necessary business expense.

For fully insured plans, the PCORI fee is paid by the health plan issuer, not the plan sponsor. Therefore, the plan sponsor does not need to take any action.

Calculating the PCORI Fee

The PCORI fee is determined by the average number of covered lives under each policy or plan, multiplied by the applicable dollar amount for the year.

To calculate the average number of covered lives, the issuer or plan sponsor must use one of the following methods:

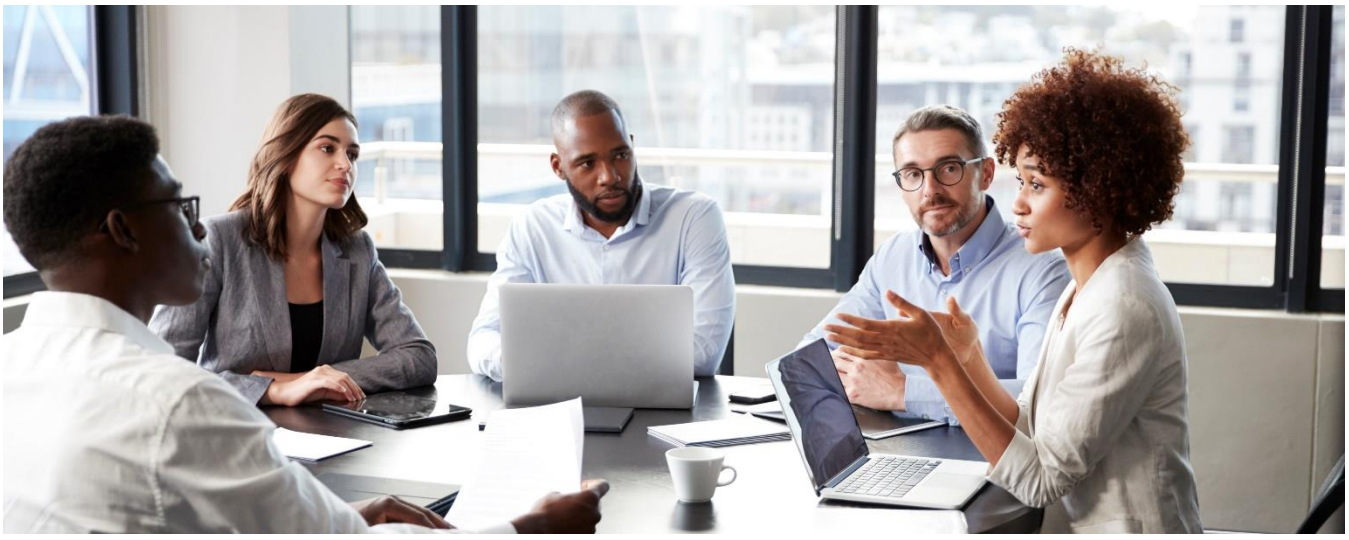
- Actual count method
- Snapshot method
- Form 5500 method (only for self-insured plans)
- Member months method (only for health insurance policy issuers)
- State form method (only for health insurance policy issuers)

For HRAs and health flexible spending accounts (FSA) that are *not* excepted benefits, plan sponsors or issuers must follow special counting rules based on other plans provided, or not provided, by the employer. These include:

- Stand-alone. If the HRA or health FSA is not integrated with a self-insured plan, then the employer must count each employee with an HRA or health FSA as a covered life.
- Integrated with fully insured coverage. If the HRA or health FSA is integrated with fully insured coverage, then the employer must count one covered life for each employee with an HRA or health FSA.
- Integrated with self-insured coverage. If the HRA or health FSA is integrated with self-insured coverage, then the employer must count each individual covered by both plans but should only be counted once.

What Employers Should Do Next

Employers should mark their calendar for July 31, 2024, as the due date for the PCORI fee submission. Work with your insurance carrier or broker to ascertain the number of applicable lives for the fee.



Tenth Circuit Rules that ERISA Preempts Oklahoma State Laws Regulating PBMs

On August 15, 2023, the U.S. Court of Appeals for the Tenth Circuit (the "Tenth Circuit") issued its decision in *Pharmaceutical Care Management Association (PCMA) vs. Mulready* (the "PCMA Case") ruling that state laws regulating pharmacy benefit managers (PBMs) are preempted by the Employee Retirement Income Security Act of 1974 (ERISA).

Understanding Preemption

ERISA allows multistate employers to design and administer their health and welfare plans – tailored to their specific workforces – uniformly, no matter where their employees live or work. This principle is called preemption, meaning that ERISA preempts any state or local laws that "relate to" an ERISA employee benefit plan.

Despite this federal policy, there is a continuing wave of state and local laws attempting to impose benefits design, reporting, and recordkeeping mandates on employers and their benefit plans. These laws are commonly challenged in court to determine whether employers must comply with state laws as they relate to their benefit plans.

One recent case involved state laws and their impact on pharmacy benefit managers.

The PCMA Case

In 2019, Oklahoma's state legislature enacted the Patient's Right to Pharmacy Choice Act (the "Act"), which regulated PBMs by establishing access to pharmaceutical providers while prohibiting restrictions on a patient's right to choose a pharmaceutical provider.

PCMA challenged the Act, claiming that ERISA preempted the state laws.

On appeal, the 10th Circuit overturned the lower court, holding that ERISA preempted the Act. In its ruling, the 10th Circuit stated, in part, that the Act's provisions struck "at the heart of network and benefit design," specifically in that the Act requires providers "to structure plans in particular ways.

What Happens Next?

Industry experts predict that this case may face additional litigation until it potentially lands on the steps of the U.S. Supreme Court. Until then, or until other federal appellate courts take up the same issue, the 10th Circuit opinion is not binding on all 50 states – leaving room for more litigation, interpretation, and application of state PBM laws.