Tulsa Employee Benefits Group Legislative Update

AUGUST 18, 2022

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Retirement Plans

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Pending Retirement Legislation

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Pending Retirement Legislation

Three primary retirement bills pending in Congress:

- Securing a Strong Retirement Act (H.R. 2954, passed by the House on March 29, 2022 and sometimes referred to as "Secure 2.0".)
- Retirement Improvement and Savings Enhancement to Support Healthy Investments for the Nest Egg Act (S. 4353, reported out of the Senate HELP Committee on June 14, 2022 and referred to as the "Rise and Shine Act".)
- The Enhancing American Retirement Now Act (the "EARN Act", reported out of the Senate Finance Committee on June 22, 2022.)

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Pending Retirement Legislation

Following is a summary of some – but not all – of the potential changes. Most of these changes are in at least two of the pending bills.

- RMD age increased incrementally to age 75 by 2033. (EARN Act increases RMD to 75 in 2032; no phase-in).
- RMD excise tax reduced from 50% to 25%. If RMD failure is corrected in timely manner, excise tax is reduced from 25% to 10%.
- Catch-up contributions increased to $10,000 at age 62, 63 and 64. (Ages 60-63 in the EARN Act).
- All catch-up contributions to be made as Roth contributions (possible income threshold).

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Pending Retirement Legislation

- Plan participants may be given the option to receive matching contributions on a Roth basis. (EARN Act also permits this for nonelective contributions)
- Employers permitted to offer *de minimis* financial incentives to boost participation in retirement plans (applicable to 401(k) and 403(b) plans).
- Student loan payments can be treated as elective deferrals for purposes of matching contributions (applicable to 401(k), 403(b) and governmental 457(b) plans).
- Cash-out limit increased from $5,000 to $7,000.

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Pending Retirement Legislation

- Employers may rely on employee certification that a hardship distribution is on account of a deemed hardship event and that such amount is not in excess of the need.
- Repayment of birth or adoption withdrawals limited to 3 years (to confirm availability of refund).
- Distributions to domestic abuse victims (subject to limits) permitted without 10% penalty. Amounts may be repaid within 3 years.
- Discretionary amendments that increase benefits accrued may be adopted by the due date of the employer's tax return for the applicable year.

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Pending Retirement Legislation

- Expansion of self-correction for inadvertent failures and for loan errors; EPCRS available for certain IRA failures.
- Plan may choose not to obtain repayment of an inadvertent benefit overpayment or may amend the plan to increase benefit payments to adjust for the overpayment.
- Relief for automatic enrollment failures (though correction method to be determined through guidance).
- Creation of "Retirement Lost and Found" registry – national online searchable lost and found database.

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Pending Retirement Legislation

- Long-term part-time worker rule modified to reduce 3-year requirement to 2-years.
- Separate top-heavy testing for plans covering excludible employees.
- Modification to RMD restrictions on life annuities relating to commercial annuities (e.g., guaranteed annual increases and return of premium death benefits to be permitted.)
- For QLACs: (i) 25% of account balance limit eliminated; (ii) dollar limit revised to $200,000; (iii) clarify that a divorce after purchase would not affect permissibility of J&S benefits; and (iv) 90-day free look period permitted.

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Pending Retirement Legislation

- Earnings, QNECs and QMACs can be withdrawn from 403(b) plans as part of hardship distributions (conforming to 401(k) plan rules).
- 403(b) plans can be multiple employer plans; express exception for church plans.
- 403(b) plans permitted to invest in Rev. Rul. 81-100 group trusts (collective investment trusts) and insurance company separate accounts.
- Elimination of “first day of the month” requirement for governmental 457(b) plans (but not for other tax-exempt employers).

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H.R. 5376

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H.R. 5376

- "Inflation Reduction Act" signed by President Biden on August 16, 2022.
- Prescription Drug Pricing
  - Government to negotiate maximum prices for brand name drugs that don't have generic competition. Negotiated prices not available to commercial purchasers.
  - Drug manufacturers must pay a rebate to the government if the price of a brand name drug rises faster than inflation, but prices paid by the commercial market are not included in calculating the rebate.

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H.R. 5376

- Three-year extension of enhanced subsidies for coverage purchased through an ACA exchange.
- $35 monthly copayment cap for insulin for Medicare beneficiaries. Cap does not apply to employer plans.
- High deductible plans are not required to have a deductible for insulin.

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SECURE and CARES Act Amendment Deadlines

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SECURE and CARES Act Amendment Deadlines

- IRS Notice 2022-33 delays the deadlines to adopt certain required CARES, SECURE, and Bipartisan American Miners Act plan amendments.
  - Originally due for most plans by the end of 12/31/22.
- Extended for qualified retirement plans and 403(b) plans until 12/31/25. Different rule for governmental plans.
- Plan administration must conform with requirements even though amendments are delayed.

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SECURE and CARES Act Amendment Deadlines

- Some amendment deadline are NOT extended:
  - CARES Act amendments for coronavirus distributions and loan relief still due by the last day of the first plan year beginning on or after January 1, 2022 (2024 for governmental plans).
  - Amendments needed for any disaster tax relief changes adopted under the Taxpayer Certainty and Disaster Tax Relief Act of 2020 are still due by the last day of the first plan year beginning on or after January 1, 2022 (2024 for governmental plans).

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RMDS: SECURE Act & Proposed Regulations

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RMDs – Age 72

- The age at which RMDs are required to begin has increased from 70½ to 72.
- Applies to distributions required to be made after 2019, with respect to individuals who attain age 70½ after 2019.

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BENEFICIARY RMDS

- Subject to significant exceptions, distribution to designated beneficiaries must be completed by end of 10th calendar year following the IRA owner/participant's death.
- Applies to IRAs and defined contribution plans (including governmental 457(b) plans).
- Effective for distributions with respect to employees who die after 2019 (2021 for governmental plans and certain collectively bargained plans).

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BENEFICIARY RMDS

- Life expectancy distribution still available to "eligible designated beneficiaries" (EDBs):
  - Surviving spouse.
  - Disabled under Code § 72(m)(7).
  - Chronically ill.
  - Not more than 10 years younger than the IRA owner/participant.
  - Minor child of IRA owner/participant (upon age of majority, 10-year rule applies).

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Beneficiary RMDs

- Eliminates the common planning technique referred to as the "stretch IRA."
- If no "designated beneficiary" (e.g., an estate), current 5-year rule continues to apply.
- Change does not apply to certain commercial annuities in effect on 12/20/19, if participant had made irrevocable election regarding distributions prior to 12/20/19.

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Proposed RMD Regulations

- Restatement of 401(a)(9) regulations proposed on February 24, 2022.
- Applicable for determining RMDs for 2022 and after. Good faith relief not extended to 2022 (so applies only for 2021).

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PROPOSED RMD REGULATIONS

- A plan must specify which RMD method applies (10-year rule or life expectancy rule) for an eligible designated beneficiary who does not make (or is not permitted to make) an election.
- Age of majority is 21 for eligible designated beneficiary purposes.
- Details provided for determination of disabled and chronically ill.

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PROPOSED RMD REGULATIONS

- Multiple beneficiaries:
  - Oldest beneficiary will generally determine RMD calculations and whether 10-year rule applies.
  - If one beneficiary is not an eligible designated beneficiary, then eligible designated beneficiary treatment not permitted for any beneficiary.
  - Unclear whether separate accounting can avoid these rules.

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Fiduciary Litigation – Hughes v. Northwestern University

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HUGHES V. NORTHWESTERN UNIVERSITY

- *Hughes v. Northwestern University*, U.S., No. 19-1401 (January 24, 2022).
- Allegations of violation of ERISA's fiduciary duty of prudence with respect to:
  - Monitoring and controlling recordkeeping fees.
  - Offering "retail" share classes of mutual funds and annuities with higher fees than identical "institutional" share classes of the same investments.
  - Offering too many investment options (over 400) that resulted in participant confusion and poor investment decisions.

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HUGHES V. NORTHWESTERN UNIVERSITY

- The District Court granted defendants' motion to dismiss the case and the 7th Circuit affirmed, citing the plan's array of investment choices that included the types of funds plaintiffs wanted (e.g., low cost index funds).
  - In the 7th Circuit's view, these offerings "eliminat[ed] any claim that plan participants were forced to stomach an unappetizing menu."
  - "[P]lan participants had options to keep the expense ratios and, therefore, recordkeeping expenses, low."

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HUGHES V. NORTHWESTERN UNIVERSITY

- The Supreme Court disagreed with the 7th Circuit's rationale, concluding that the 7th Circuit's focus on investor choice ignored plan fiduciaries' obligation to conduct their own independent evaluation to determine the prudence of investment options.
- Case remanded for the 7th Circuit to consider whether the plaintiffs' plausibly alleged a violation of the duty of prudence using the pleading standard articulated in *Tibble v. Edison Int'l*.
- Tibble: A fiduciary normally has a continuing duty of some kind to monitor investments and remove imprudent ones.

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HUGHES V. NORTHWESTERN UNIVERSITY

- "At times, the circumstances facing an ERISA fiduciary will implicate difficult tradeoffs, and courts must give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise."

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FIDUCIARY LITIGATION

- Recent series of lawsuits focused on passively managed (indexed) target date funds.
- Recent lawsuit alleging breach of fiduciary duty relating to managed account service.
  - Fees alleged to be unreasonable.
  - Service alleged to be duplicative of available target date fund strategies.

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Miscellaneous

DOL Comments on Cryptocurrencies

- DOL Compliance Assistance Release 2022-01 (3/10/22) cautioned 401(k) plan fiduciaries about allowing investments in cryptocurrencies.
  - Cryptocurrencies include digital assets such as those marketed as tokens, coins, crypto assets and derivatives of such.
- DOL "has serious concerns about the prudence of a fiduciary's decision to expose a 401(k) plan's participants to direct investments in cryptocurrencies, or other products whose value is tied to cryptocurrencies."

DOL Comments on Cryptocurrencies

- Per the DOL, these sorts of investments involve "significant risks and challenges to participants' retirement accounts" including risks for fraud, theft, and loss from:
  - Speculative and volatile nature of such investments.
  - Lack of expertise to make informed decisions related to such investments.
  - Custodial and recordkeeping concerns.
  - Valuation concerns related to reliability, accuracy, and the complexity of valuing such investments.
  - Evolving regulatory environment and possibility that the sale of some cryptocurrencies could be an unlawful transaction.

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DOL Comments on Cryptocurrencies

- EBSA indicates it will conduct an investigative program targeting plans that offer participants investment in cryptocurrencies and related products either through an investment option or through a brokerage window.
- Plan fiduciaries should "expect to be questioned" about how they have satisfied their duties of prudence and loyalty if they offer such investments as an investment option or allow investment in the plan through a self-directed brokerage account.

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DOL Comments on Cryptocurrencies

- Comments have been criticized due to absence of notice and comment process and indication that brokerage window investment of cryptocurrency would be scrutinized.
- Legislation introduced on May 5 by Sen. Tuberville prohibits government restrictions on specific types of investments.
- Lawsuit filed on June 2 by 401(k) provider ForUsAll Inc. alleges violation of administrative process.

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State IRA Laws

- Many states have or are in the process of adopting mandatory automatic enrollment payroll deduction IRA programs employers may need to facilitate.
  - Illinois, California, Connecticut, and Oregon programs are implemented.
  - Colorado, Hawaii, Maine, Maryland, New Jersey, New York, Virginia, Seattle, and New York City have enacted programs that are in the process of implementation or development.
  - Delaware recently passed a law that is awaiting the governor's signature.
- Active legislation in many other states.

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State IRA Laws

- Generally, employers are exempt from these programs if they offer a qualified retirement program such as a 401(k) or 403(b) plan.
- However, employers that are exempt may be required to report their exemption from the program.
  - Registration of an employer's exemption is required in Illinois (Illinois Secure Choice Savings Program Act), Oregon (OregonSaves), and Connecticut (Connecticut Retirement Security Program).

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State IRA Laws

- Under some state programs, it is not clear if all employees need to be eligible for the employer's qualified retirement plan for an otherwise covered employer to be exempt.
- Hawaii's newly enacted law mandates facilitation of the state program unless the employer maintains a qualified retirement plan "for all of its employees."

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Lifetime Income Disclosures

- SECURE Act added ERISA requirement for retirement plans to provide annual disclosure regarding annuity income streams that could result from participant account balances.
- Participant-directed plans must incorporate lifetime illustration on any quarterly statement no later than the second quarter of 2022 (ending June 30, 2022).

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Remote Notarization

- Physical presence requirement relief extended to December 31, 2022.
- IRS Notice 2022-27 extends relief originally provided in Notice 2020-42 and extended in Notice 2021-3 and 2021-40.
- Relief from physical presence requirement for participant election witnessed by a notary public of a state that permits remote electronic notarization or by a plan representative.
- Subject to requirements listed in Notice 2021-3 regarding interaction between participant and witness.

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Welfare Benefit Plans

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Oklahoma Legislation

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Oklahoma PBM Legislation

- PBM law was originally passed in 2019 (HB 2632) and was amended in 2022 (SB 737). It potentially impacts common Rx plan designs.
- Earlier this year, a federal district court held that ERISA does not preempt its application to self-funded benefit plans. The trade group that brought the lawsuit is appealing.
- The Insurance Department has indicated that it is prepared to enforce. https://www.oid.ok.gov/release_040522/
- PBMs are regulated, but beware of contractual responsibility.

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Oklahoma Insulin Legislation

- Effective 11/1/21, Oklahoma law imposes certain requirements on insulin coverage. In particular, a participant's out of pocket for insulin is limited to $30 per 30-day supply or $90 per 90-day supply.
- The Oklahoma Insurance Department has taken the position that this law is not preempted by ERISA. https://www.oid.ok.gov/bulletin-no-lh-2021-04/
- Amended effective 11/1/22 to attempt to more clearly cover self-funded plans ("employer self-insured plan as permitted under" ERISA).
- Federal insulin legislation also in progress.

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Mental Health Parity

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Mental Health Parity

- Group health plans and insurers must provide to federal and state agencies – upon request – a comparative analysis of nonquantitative treatment limitations ("NQTLs") related to mental health and substance abuse disorder benefits ("MH/SUD").
  - NQTLs – generally, a limitation on the scope or duration of benefits for treatment that is not expressed by number.
- DOL, HHS, and Treasury Departments must request at least 20 comparative analyses per year.

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Mental Health Parity - Report

- On January 25, 2022, the Departments issued their first annual MHPAEA Report to Congress after the imposition of the new comparative analyses requirements.
- EBSA began requesting MHPAEA comparative analyses April 10, 2021 (2 months after the new comparative analyses requirements took effect).
- 156 letters were issued to plans and issuers for comparative analyses and none of the comparative analyses reviewed contained sufficient information.
- EBSA issued 80 insufficiency letters requesting additional information related to 170 NQTLs.

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Mental Health Parity - Report

- In 2021 EBSA also closed investigations with 74 health plans that involved MHPAEA (41 self-insured plans, 17 fully-insured plans, and 16 plans that offered both fully-insured and self-insured options).
  - EBSA reported 14 MHPAEA violations in 12 of such investigations.

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Mental Health Parity - Report

Common deficiencies in comparative analyses:

- Failure to document comparative analyses before designing and applying NQTL.
- Conclusory assertions lacking specific supporting evidence or detailed explanations.
- Lack of meaningful comparisons or meaningful analysis.
- Many comparative analyses used a table format with separate columns for MH/SUD and M/S. The same general text was in both columns with conclusory statements rather than detailed meaningful comparisons or explanations.

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Mental Health Parity - Report

Common deficiencies in comparative analyses:

- Generically prepared by a service provider and not properly addressing the applicable plan or coverage.
- Failure to identify methodologies used within benefit classifications or by third party pricing entities for OON reimbursement rates.
- Use of generic terms such as “cost containment” or “high-cost services” without precise definitions.
- Failure to demonstrate compliance of a NQTL as applied.
    - Evidence that preauthorization or network admission standards were actually applied in parity.

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Mental Health Parity - Report

- EBSA has issued 30 initial determination letters to plans and issuers finding 48 NQTLs (36 unique NQTLs) related to MH/SUD benefits lacked compliant parity.
- Some plans and issuers decided to remove a NQTL after receiving an initial request, insufficiency letter, or follow-up request from EBSA, even when EBSA had not issued an initial determination of non-compliance.
- 26 plans and issuers have agreed to make prospective changes to their plans.

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Mental Health Parity - Report

Examples of changes to MH/SUD benefits in response to EBSA review:

- Removal of ABA therapy exclusions or restrictions.
- Service provider notified clients it would not apply ABA exclusion prospectively and would require plans take corrective action regarding prior denied claims.
- Removal of exclusion of medication-assisted treatment for opioid use disorder.
- Removal of exclusion for anorexia nervosa, bulimia nervosa, and binge-eating disorder.
- New internal procedures for handling claims for urine drug testing (stopped automatic denial).

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Mental Health Parity - Report

Examples of changes to MH/SUD benefits in response to EBSA review:

- Removal of blanket precertification requirement for all outpatient MH/SUD services.
- Removal of impermissible separate treatment limitations.

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Mental Health Parity - Report

NQTLs that lacked parity (in order of frequency):

- Limitation or exclusion of applied behavioral analysis (ABA) therapy or other services to treat autism spectrum disorder.
- Billing requirements – licensed MH/SUD providers can bill the plan only through specific types of other providers.
- Limitation or exclusion of medication-assisted treatment for opioid use disorder.
- Preauthorization or precertification requirements.
- Limitation or exclusion of nutritional counseling for MH/SUD conditions.
- Provider experience requirement beyond licensure.

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Mental Health Parity - Report

NQTLs that lacked parity (in order of frequency):

- Care manager or specific supervision requirement for MH/SUD.
- Exclusion or limitation on residential care or partial hospitalization to treat MH/SUD conditions.
- "Effective treatment" requirement applicable only to SUD benefits.
- Treatment plan requirement.
- Employee assistance program referral requirement.
- Exclusion of care for chronic MH/SUD conditions.
- Exclusion of speech therapy to treat MH/SUD conditions.

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Mental Health Parity - Report

NQTLs that lacked parity (in order of frequency):

- Concurrent care and discharge planning requirements.
- Retrospective review.
- Maximum allowable charge and reference-based pricing.
- Other exclusion specifically targeting MH/SUD benefits.
- Age, scope, or duration limits.
- Formulary design.
- Limit on telehealth for MH/SUD.
- Restriction on lab testing for MH/SUD.

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Mental Health Parity - Report

Examples of complaints EBSA benefit advisors referred to an EBSA investigator for potential violations:

- Difficulty locating a mental health network provider and inaccurate provider list.
- SUD residential treatment facility contacted EBSA regarding reimbursement issues.
- Participant complaint for failure to cover ABA therapy beyond 25th day/year without meeting certain medical necessity criteria.

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Mental Health Parity - Report

Examples of complaints EBSA benefit advisors referred to an EBSA investigator for potential violations:

- Participant complaint regarding an OON anesthesia bill brought to light separate potential MHPAEA violations related to co-pays for outpatient mental health visits.
- COBRA participant's complaints regarding continued access to EAP benefits brought to light an additional possible MHPAEA violation in the plan's SBC related to preauthorization requirements.

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Wellness Benefits

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WELLNESS BENEFITS

- ADA and GINA generally prohibit employers from requiring medical exams or inquiries unless it is part of a "voluntary wellness program."
- 2016 ADA and GINA regulations provided a safe harbor for incentives or penalties that could be applied under a "voluntary" wellness program.
- Following litigation initiated by AARP, EEOC withdrew the incentive/penalty percentage safe harbor portions of the 2016 regulations at the end of 2018.

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Wellness Benefits

- EEOC issued proposed wellness regulations under ADA and GINA on 1/7/21.
  - Limited participatory wellness programs (that involve disclosure health info) to "de minimis" incentive (e.g., a water bottle or a modest gift card).
  - Health contingent programs offered through a health plan would be subject to HIPAA incentive limits (30%/50% for tobacco).
- EEOC withdrew the proposed regulations on 2/12/21.
- Future regulation expected when Biden administration fills EEOC vacancies.

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Yale Wellness Plan Settlement

- Yale University wellness program included a $25 per week ($1,300 annual) surcharge for employees who opted out of the wellness program or did not complete required screenings.
  - Surcharge also applied if spouse failed to complete screenings.
- Yale employees (with AARP assistance) filed class action in 2019 alleging violation of ADA and GINA due to required involuntary disclosure of health information.

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Yale Wellness Plan Settlement

- On March 4, 2022, the parties requested approval of a settlement with the following terms:
  - Yale to pay $1.29 million to certain impacted employees and for attorneys' fees.
  - Yale to cease collecting the surcharge fees for a period of 4 years, or until the law expressly allows wellness plans to apply such incentives/penalties.
  - An employee will be required to provide a HIPAA consent before data is transferred to health coaches, and certain data previously collected will be purged.

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Proposed Section 1557 Regulations

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Proposed Section 1557 Regulations

- On July 25, 2022, HHS Office for Civil Rights ("OCR") released proposed regulations under Section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs and activities.
- The proposed regulations largely restore the Obama Administration's Section 1557 regulations (which the Trump Administration had scaled back).
- The proposed regulations do not apply directly to self-insured plans, but they do apply to insurers and TPAs that administer self-insured plans, if they receive direct or indirect Federal financial assistance ("FFA").

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Proposed Section 1557 Regulations

- Prohibit benefit designs that impermissibly limit coverage based on a person's sex at birth, gender identification, or gender otherwise recorded.
- Provide that "discrimination on the basis of sex" includes discrimination based on sex stereotypes, sex characteristics, pregnancy or related conditions, or sexual orientation and gender identity (a follow up to the Supreme Court's 2020 decision in Bostock v. Clayton County).
- Reinstate and expand notice requirements and require covered entities to put in place new policies and procedures, including grievance procedures, on Section 1557 and to train employees.

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Proposed Section 1557 Regulations

- Interpret the phrase "health programs or activity" broadly to include providing or administering health-related services. However, the proposed rule clarifies that it does not apply to a covered entity in its capacity as an employer with respect to employment practices.
- TPAs that develop plan or policy documents or terms that are adopted by a plan sponsor may be held responsible for Section 1557 violations.
- HHS may refer or transfer matters to other federal agencies (such as the EEOC) if discriminatory feature originated with self-insured plan.

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No Surprises Act Update

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No Surprises Act

- Applicable to:
  - Emergency services performed by nonparticipating providers/facilities at a participating or nonparticipating facility.
  - Non-emergency services performed by nonparticipating providers at participating facilities (absent the patient's informed consent, where permitted by the Act).
  - Air ambulance services.
- Effective for plan years beginning on or after 1/1/2022.
- Two sets of Interim Final Rules have been issued.

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No Surprises Act

- The Act prescribes how a health plan must calculate a participant's cost-sharing amount.
- Cost-sharing payments must be applied to the participant's in-network deductibles and maximum out-of-pocket limits.
- Nonparticipating providers and facilities may not "balance bill" patients for any amounts in excess of the cost-sharing amounts unless the patient has provided informed consent, which is only allowed in certain circumstances.

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No Surprises Act – ER Services

Interim Final Rule – Part I Clarifications

- If a plan covers Emergency Services, such coverage must be provided without regard to any other term or condition of the coverage (other than coordination of benefits, an affiliation or permitted waiting period, and applicable cost sharing).
- Plans may not deny coverage for Emergency Services based on any general plan exclusion that would apply to Emergency Services.
- Example in preamble: A plan cannot deny claims for emergency services furnished to a pregnant dependent based upon a general plan exclusion for dependent maternity care.

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No Surprises Act – ER Services

Interim Final Rule – Part I Clarifications

- The term "emergency department" of a hospital can include an outpatient department.
- The term "emergency medical condition" includes a mental health condition or substance use disorder.
- A plan cannot limit what constitutes an emergency medical condition solely on the basis of diagnosis codes.

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No Surprises Act – ER Services

Interim Final Rule – Part I Clarifications

- Emergency Services
  - Includes services at an independent freestanding emergency department (which can include an urgent care center if licensed).
  - Includes certain post-stabilization services by out-of-network providers regardless of the department of the hospital in which the services are furnished. This can include certain in-patient and outpatient stays and outpatient observation.
  - In-patient admissions that follow an ER visit may be subject to the No Surprises Act protections.

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No Surprises Act – ER Services

Interim Final Rule – Part I Clarifications

- Emergency Services
  - Coverage may not be restricted by imposing a time limit between the onset of symptoms and when services are sought at the emergency department and cannot require sudden onset of the condition.

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No Surprises Act – Non-ER Services

Interim Final Rule – Part I Clarifications

- Notice and consent is not allowed for items or services furnished as a result of unforeseen, urgent medical needs that arise when an item or service is provided.
- Notice and consent is allowed for services post-stabilization in an emergency.
- Providers must notify plan of consent when transmitting the bill and provide a copy of the signed consent document.
- Plan may rely on such notice unless it knows or reasonably should know that the consent was not properly given.

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No Surprises Act – Dispute Resolution

Interim Final Rule – Part II Clarifications

- IDR entity must begin with the presumption that the QPA amount is the appropriate OON rate. *(However, see later slides regarding the impact of court decision on this requirement.)*
- Any additional circumstances considered must be critical to actual delivery of care. For example, if the service is simple wound care, a higher rate for a provider with more experience is not justified.

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No Surprises Act – Dispute Resolution

- Health plans must make an initial payment or deny claims of non-participating providers/facilities that are subject to the surprise billing provisions within 30 days of receiving the clean claim.
- **Interim Final Rule – Part I Clarifications**
  - The "initial payment" is not an initial installment, but is the amount the plan intends for payment in full.
  - The QPA must be included with the initial payment.
  - Must also include a statement certifying that the QPA was determined in compliance with the regulations and must provide information regarding IDR process.
  - Additional QPA information must be provided to the provider or facility upon request.

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No Surprises Act – Dispute Resolution

Interim Final Rule – Part II Clarifications

- A federal IDR portal required to be used as part of the process.
- The IDR process may be used to determine the proper service code for an item or service. For example, if the provider argues that the plan downcoded the service code.
- Each party will propose a payment amount to the IDR entity. The IDR entity must select one party's amount (and reject the other party's amount). Compromise amount not permitted.
- IDR entity must decide within 30 days.

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No Surprises Act – Dispute Resolution

- IDR entities shall not consider:
  - Usual and customary charges.
  - Provider or facility charges.
  - Medicare, Medicaid, CHIP or Tricare rates.
- IDR entities shall consider:
  - The "offer" amount, i.e., the payment amounts that the provider and payer are proposing as a settlement amount.
  - Information requested by the IDR entity regarding the offer amounts.

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No Surprises Act – Dispute Resolution

- IDR entities shall consider: (continued)
  - Information submitted by the IDR parties regarding their offer or the opposing offer.
  - The "qualifying payment amount" (generally the median of the contracted rates recognized by plan for similar services in same geographic region).
  - In the case of air ambulance payment disputes, the population density of the pickup location (such as urban, suburban, rural or frontier).

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No Surprises Act – Dispute Resolution

- IDR Fees
  - CMS's Technical Guidance 2021-01 prescribes the 2022 IDR fees.
  - Each party pays an administration fee ($50 for 2022).
  - The losing party also pays the IDR entity's fee.
    - For 2022, IDR fees for a single determination may range from $200-$500.
    - Batched determinations may range from $268-$670.

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Texas Medical Association v. DHHS

- On February 23, 2022, the U.S. District Court for the Eastern District of Texas vacated the IFR's provisions that effectively required a rebuttable presumption for the IDR entity to select the offer closest to the QPA under the arbitration process.
- In the court's view, the "rebuttable presumption" requirement:
  - Improperly "places its thumb on the scale for the QPA."
  - Conflicts with the unambiguous text of the NSA that does not require such presumption.
  - Impermissibly bypassed procedural requirements by imposing such a presumption.
- Subsequent guidance has removed invalidated portions of rule.

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LIFENET V. DHHS

- In LifeNet, Inc. v. DHHS, 2022 WL 2959715 (E.D. Tex. 2022)(July, 26, 2022), the same court vacated portions of IDR provisions related to air ambulance services, on similar grounds to the Texas Medical Association.

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Transparency Reminders

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TRANSPARENCY REMINDERS

- Machine Readable Files for network rates and out-of-network amounts – to be posted on public websites by July 1, 2022.
  - Posting requirement for prescription drug prices currently delayed.
- Prescription drug and health care spending reporting - reporting for 2020 and 2021 due by December 27, 2022, and by June 1 thereafter.
- Air ambulance services – reporting due for 2022 by March 31, 2023 and for 2023 by March 30, 2024.

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TRANSPARENCY REMINDERS

- Advanced explanation of benefits – pending future guidance.
- Attestation of prohibition of gag clauses – no guidance yet, though effective for 2022.
- Price comparison tool – January 1, 2023 for 500 specific items and services; January 1, 2024 for all covered items and services.

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Transparency Reminders

- Already effective:
  - Cost-sharing information required on ID cards.
  - Continuity of care requirements.
  - Provider directory requirements – must be updated at least quarterly.
  - Service provider disclosure requirements.

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Outbreak Period Reminder

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TEMPORARY "OUTBREAK PERIOD" RELIEF

- Outbreak period relief, which began March 1, 2020, still applicable.
  - HIPAA special enrollment
  - COBRA elections and payments
  - Claims and appeals
  - External review of denied health plan claims
  - Plan notices

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TEMPORARY "OUTBREAK PERIOD" RELIEF

- EBSA Disaster Relief Notice 2021-01: "Outbreak Period" determined on a *person by person* (*event by event*) basis and continues until the earlier of:
  - 60-days after the announced end of the national emergency, or
  - One year from when the person is first eligible for relief.
- On February 18, 2022, President Biden announced that he was continuing the "national emergency" declaration beyond March 1, 2022.

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Miscellaneous

Telehealth Exemption For HDHP/HSA

- Consolidated Appropriations Act of 2022 (enacted on March 15, 2022) includes a temporary extension to treat telehealth and other remote care services as disregarded coverage under Code Section 223 from April 1, 2022 through December 31, 2022.
- Therefore, coverage of telehealth and other remote care services without applying a HDHP deductible from April 1, 2022 through December 31, 2022 will not impact an HDHP participant's HSA eligibility or the status of HDHP coverage.
  - Coverage without deductible during January-March 2022 would cause loss of HDHP status.

Telehealth Exemption For HDHP/HSA

- Plans are not required to provide telehealth services without the HDHP deductible.
- There may be administrative considerations about whether to provide this relief since it is only available for part of 2022.
- If a plan elected to cover telehealth services without the HDHP deductible in 2022, they cannot provide that treatment from January 1, 2022 through March 31, 2022 without jeopardizing the HDHP status of the plan.

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HSA/HDHP/EBHRA Limits

Revenue Procedure 2022-24

- 2023 limits for HSAs and HDHPs

	Calendar Year 2022		Calendar Year 2023	
	Self-only	Family	Self-only	Family
Annual Contribution Limit	$3,650	$7,300	$3,850	$7,750
HDHP Minimum Deductible	$1,400	$2,800	$1,500	$3,000
HDHP Out-of-Pocket Limit (includes deductibles, co-payments and other amounts but not premiums)	$7,050	$14,100	$7,500	$15,000

- The minimum amount that can be made available to excepted benefit HRAs in 2023 is $1,950 (up from $1,800 in 2022).

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ACA Reminders

- ACA employer mandate (pay or play rules) still apply.
  - 4980H(a) (95% rule): Projected to be $2,880 per employee for 2022.
  - 4980H)(b): Projected to be $4,320 per employee for 2023.
- Affordability percentage adjusted to 9.12% for plan years beginning in 2023. (2022 was 9.61%.)
  - Confirm use of safe harbors if applicable.

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ACA Reminders

- 2023 Out-of-pocket limits (note that HDHP limits are lower):
  - Individual: $9,100
  - Family: $18,200
- Confirm newly required preventive services.

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The foregoing presentation is a summary of certain legislation and guidance. As with any summary, some details are omitted.

This summary should not be relied upon for legal or tax advice for particular situations.

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