BHCG BUSINESS HEALTH CARE GROUP

DELIVERING VALUE SERIES

Hot Topics in Benefits Law

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Welcome

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Agenda

- CARES Act & Other COVID-19 Guidance
- Other Health & Welfare Developments
- 2021 Preview

Health & Welfare Plan Changes

- Group health plans must cover certain, specified testing during Coronavirus emergency period
  - Cannot impose any cost-sharing requirements (deductibles, copayments, coinsurance) or "prior authorization or other medical management requirements"
  - Coverage of testing (and treatment) on pre-deductible basis will not destroy high deductible health plan status
- Establishes what a self-funded health plan must pay for coronavirus testing
  - If had negotiated rate before emergency declaration, use that
  - If not, look to cash price on provider's public internet website or negotiate price
- Vaccines & preventative services
  - "Speed up" coverage if and when vaccine or other preventive coverage becomes possible (15 calendar days after announced)

Health & Welfare Plan Changes (Cont.)

- OTC Drugs: Removes ACA limitation on health FSA, HRA, HSA reimbursement of over-the-counter medicines
  - Optional; can be retroactive to 1/1/2020
  - Also clarifies that menstrual care products can be reimbursed
- Telehealth: "Telehealth and other remote care services" may be provided by a high-deductible health plan, without destroying HSA eligibility
- Student Loans: $5,250 tax exclusion for employer payments toward certain employee student loans through December 31, 2020
  - Must meet certain administrative requirements (e.g., written plan)
  - Different than prior law, which focused on current education, not prior education

Health & Welfare Plan Changes (Cont.)

- On April 28, 2020 the IRS and DOL issued new regulations providing relief for plan enrollees from certain deadlines
- Relief retroactively effective to March 1, 2020; applies to most plans
- Relief applies for 8 different enrollee deadlines
- (1) HIPAA special enrollment (usually 30 days after special enrollment event, but can be 60 days for some events)
  - Does NOT protect initial enrollment – employers CAN enforce those
- (2) COBRA election period (60 days)
  - Does not seem to affect state "mini-COBRA" laws
- (3) Time to make COBRA premium payments (45 days for first payment; 30 days for subsequent payments)

Health & Welfare Plan Changes (Cont.)

- (4) Date for COBRA qualified beneficiary to notify plan of disability or second qualifying event
- (5) Date within which individuals may file a benefit claim under plan's claims procedures, per ERISA regulations
- (6) Date to file an appeal of a denied claim (ERISA)
- (7) Date by which claimants may request external review
  - Would not apply to self-funded plans which are "grandfathered"
- (8) Date by which individual may file information to perfect a request for external review

Health & Welfare Plan Changes (Cont.)

- Relief was triggered by federal government's declaration of national emergency
- Under law, delays under ERISA / Code can last for a maximum of one year
  - So, it appears delays we will discuss must end on February 28, 2021
- Delays all "keyed off" date when federal government ends the national emergency
- For example, suppose it ends on December 31, 2020. Once it ends, the deadlines for plan enrollees last another 60 days; then whatever time period the enrollee had not yet "used up"

Health & Welfare Plan Changes (Cont.)

- Aaron received a COBRA election notice on February 1, 2020, while Betty received a COBRA election notice on April 1, 2020.
  - By when must Aaron elect COBRA? By when must Betty?
- Aaron's 60 days started on February 1. So he "used up" 29 days in February. So he still has not "used up" 31 days (60 - 29).
  - If the national emergency ends on 12/31/2020, the "outbreak period" lasts another 60 days, until March 1, 2021. Aaron then receives the balance of his remaining days (31), starting on March 2, 2021
  - So, Aaron has until 31 days, starting on March 2, 2021, to elect. That date is April 1, 2021. Aaron needs to have elected COBRA by then
- Betty receives full 60 days starting March 2 (so, April 30, 2021)

Affordable Care Act ("ACA") Update

- IRS Notice 2020-29: Possible to change health FSA and DCAP elections (but was not popular with employers)
- PCORI fees are back
  - New law reinstates them for an additional 10 years
  - Generally due on July 31 of each year
  - Cost is $2.54 for enrollees for plan that ends on or after October 1, 2019 and October 1, 2020
- New template summary of benefits and coverage ("SBC")
  - For plan years starting 1/1/2021 and later
  - Very similar to prior version

IRS Reporting

- New Forms 1094 / 1095, but only modest changes
  - Reporting ICHRAs
  - Continuing multiemployer plan relief
  - Similar modest extension for filing
- Due date to furnish 1095-B and 1095-C to individuals moved from 1/31/2021 to 3/2/2021

IRS Reporting

- Big concern: 2020 reporting (done in early 2021) will be last year for "good faith relief"
  - IRS under pressure to collect more penalties?
  - IRS: No statute of limitations for penalties
- Due date to furnish 1095-B and 1095-C to individuals moved from 1/31/2021 to 3/2/2021
- Penalties subject to annual adjustment
  - Code Section 4980H(a): $2,570 in 2020; $2,700 in 2021
  - 4980H(b): $3,860 in 2020; $4,060 in 2021
  - Affordability percentage: 9.78% (2020); 9.83% (2021)

State Law Mandates

- ERISA generally preempts most state laws, usually helpful
- But some state laws avoid preemption
- E.g., Oakland, CA ordinance with minimum wage of $15 with health benefits or $20 without – no preemption
- CA law on notifying employees of deadline to withdraw funds from health FSA and dependent care plan
  - If deadline to submit reimbursement is in middle of plan year
  - Likely no ERISA preemption for dependent care plan
- State breach notification laws? State data reporting?

State Law Mandates

- Rutledge v. Pharmaceutical Care Management Association
- Supreme Court heard arguments Oct. 6 on whether Arkansas law which sets the price plans will pay a pharmacy is preempted by ERISA
  - 45 states have some type of similar PBM regulation
- Justices seemed to struggle over the question
- 8th Circuit held that law was preempted

Drug Coupons

- Many drug manufacturers will offer "coupons" for plan enrollees, to bring down drug cost (at least initially)
- In 2019, CMS issued guidance stating that coupons had to "count" towards enrollee's deductible / maximum out of pocket ("MOOP")
  - E.g., drug costs $1,000; coupon of $950 applies; enrollee pays $50 in cash; does $950 count towards deductible and MOOP?
- Regulations from earlier this year say "no, not under federal law". Possible state would require it
  - Helpful for health savings account purposes

Cross-Plan Offsetting

- Complicated practice where TPA uses one plan's recovery to help another plan
- E.g., John participates in the Quarles health plan, which uses TPA. John goes to out of network provider and has $1,000 bill. TPA tells Quarles to pay $1,000, which it does. TPA pays $1,000. But then reviews bill and says it should have been $800. Provider will not refund $200
- Dollar amount too small to bring litigation

Cross-Plan Offsetting

- TPA waits for different enrollee in different plan to use same provider. Suppose Sally incurs $2,000 claim with same provider John used. Sally works for ABC Inc. ABC sends $2,000 to TPA to pay Sally's claim
- TPA sends $1,800 in cash / ACH and "forgiveness" of $200 debt to Quarles plan (which may not be accurate)
- National TPA lost in 8th Circuit on this. DOL amicus brief strongly suggests it violates ERISA. In summer 2020, a new class-action case filed

New HRA Options

- Individual coverage HRA ("ICHRA") new option in 2020
  - Allows employers to reimburse employees for cost of individual health insurance coverage
  - Subject to various provisions (e.g., "same terms" requirement; notice requirement; limit on "traditional" health plan offering)
- Excepted benefit HRA ("EBHRA") also new option in 2020
  - Under ACA, "stand-alone" HRAs generally illegal. But, this is an exception to that rule
  - Employer contribution limited to $1,800
  - Some provisions to consider also

Bostock Ruling

- June 12: HHS weakened "1557" regulations under ACA
  - Discrimination "on the basis of sex" does not include gender identity
- June 15: Supreme Court rules that Title VII (which uses similar language) prohibits employment discrimination based on LGBTQ status
- HHS regulations immediately challenged
- Verify if you are subject to 1557
- Look for plan provisions which single out enrollees based on LGBTQ status

COBRA Litigation

- Number of employers – often very large – have been sued recently over COBRA notices which were claimed to be deficient
- Minor issues were focused upon
- Recent court decision good for employers (essentially, "no harm, no foul")
- In May 2020 the DOL released new model notice
- Good time to review / update your model notice
  - Consider 1-page summary of COVID rules, too

ACA Litigation

- Texas v. California (Supreme Court, Nov. 10 arguments)
  - A few years ago Congress modified ACA to reduce individual mandate to $0
  - Texas and some other states argued that with revenue, the mandate is no longer a "tax", so provision is unconstitutional
  - Court could just strike down that mandate; provisions related to mandate; or entire ACA
    - Trump administration argued entire ACA must fall
  - If entire ACA is stricken, will be political pressure for Congress to immediately act (e.g., on preexisting condition exclusions)
  - Appears majority of justices were skeptical of Texas's position (i.e., unlikely that entire ACA will fall)

Drug Pricing

- New rules on importation of prescription drugs from Canada
  - But complex process which will probably be too difficult for employers by themselves
- President Trump's executive orders on "most favored nation" drug pricing and Medicare Part D prescription drug rebates may be in limbo under Biden administration
  - Effect unclear for employers
  - Possible effect on EGWPs; could it raise prices for employer-sponsored plans?

Surprise Billing

- Surprise billing legislation
  - Main goal is to address situations where enrollee goes out of network and receives large bill
  - Especially sympathetic when enrollee chooses in-network hospital; but doctor or specialist ends up being out-of-network
  - One proposal is to require payment at in-network rates
    - But hotly contested as a solution
  - Can plan sponsors try to address through better communication? More-clear examples? Assistance in choosing doctors and hospitals?

Price Transparency Regulations

- DOL, IRS, HHS just issued (published in Federal Register Nov. 12) final regulations for health plans and insurers
  - Flows from ACA rule
- Apply to most insurers and "group health plans"
  - Does NOT apply to grandfathered plans, HRAs, health FSAs, excepted benefits or short-term, limited-duration insurance
  - Does apply to grandmothered plans and multiemployer plans
- Goal is to make it easy for enrollees to access cost-sharing information through Internet (or app, etc.)

Price Transparency Regulations

- Plans / insurers must make advance disclosure of specified cost-sharing information to enrollees through Internet-based self-service tool
  - Also in paper form upon request
- Initial list of 500 common medical items and services must be available by 1/1/2023
  - ALL items and services by 1/1/2024
  - Does not seem to be based on plan year

Price Transparency Regulations

- Plans and insurers must disclose estimated amount of what individual would pay for a covered item / service (such as deductible, coinsurance, copayment)
  - Separate disclosures must be made if cost-sharing is imposed separately for each unique item and service in a bundled payment
- Also disclose what enrollee has incurred so far (e.g., towards deductible and maximum out of pocket)

Price Transparency Regulations

- And the rate the plan / insurer / TPA / PBM have contractually agreed to pay for item / service
  - Same is true for both in-network and out-of-network providers
  - Preamble to regulations specifically tries to rebut claims from TPAs / insurers / PBMs that the information is confidential or proprietary
  - Seems to create contractual issues. Insurers / TPAs / PBMs may have contracts (e.g., with providers) saying the information is confidential and cannot be disclosed in this manner

Price Transparency Regulations

- If the payment is a bundled payment arrangement, must list all the covered services and items
- If service is subject to a "prerequisite" (e.g., concurrent review, prior authorization, step therapy, fail-first protocol) enrollee must receive notice of same
  - Does NOT include medical necessity determinations or other medical management techniques (above list is exhaustive)

Price Transparency Regulations

- Notice with specific disclosures, including balance billing and that this may be an estimate
  - Model is 3 pages long
- Public disclosure also, for plan years starting 1/1/2022
  - In machine-readable files, updated monthly
  - Must show negotiated rates for covered items and services between plan / insurer and in-network providers
  - Also historical payments to, and billed charges from, out-of-network providers
  - Separate file for prescription drug information

Price Transparency Regulations

- Fully-insured plans can satisfy regulation by written agreement with insurer
  - Employers with a fully-insured plan: get this in writing soon
    - Insurers may choose to send such contract / language ahead of time
- Self-funded plans will likely look to TPA and PBM for help
  - TPAs and PBMs may need to hire others to assist
- Seems like a massive, "game changer" regulation
  - E.g., will public disclosure cause prices to decrease? Increase? What will third parties do with data? Will employers implement financial incentives to use "best-cost" providers?

Wellness Regulations

- IRS, DOL, HHS regulations remain "set" – no changes
- EEOC's ADA wellness regulations still in turmoil
- 2016 final regulations generally good from plan sponsor's perspective
  - Cap on wellness reward / penalty generally lower than IRS, DOL, HHS regulations, but certainty was helpful
- AARP lawsuit caused EEOC going back to drawing board
- On June 11, EEOC approved new regs – but not published yet

Direct Primary Care ("DPC")

- Proposed IRS regulations (June 2020) defined DPC arrangements as a contract between individual and primary care physician(s)
  - Individual pays fixed periodic fee; no third party billing
- Regulations confirm it is "medical care" under Code Section 213(d)
- But strongly hint that it would be an ERISA-covered plan
  - Makes it less practical for an employer to implement as alternative to group health plan

Mental Health Parity Update

- DOL updated its mental health parity self-checklist (Oct.)
- Clarifies that using different factors to establish provider reimbursement rates is a red flag
- If plan sponsor delegates responsibility to others (e.g., TPA or PBM) should ensure that they provide documentation which demonstrates compliance
- New example on provider admission to network
- Self-funded plans should discuss with TPA / PBM (or do test themselves)

Association Health Plans, etc.

- "New" association health plans remain in limbo
  - Will Biden administration end them and just keep "old" test?
- Odd case challenges DOL on what can be an ERISA plan
  - Data Marketing Partnership, LP v. DOL (Sept. 2020)
  - Tens of thousands of limited partners installed an app on their phones. App tracked their activities and reported to central entity. Central entity then offered to sell data to Google, Facebook, etc. Central entity set up health plan covering all
  - DOL: Not an employer plan. Court: Yes it is

HIPAA Update

- January 2018 regulations on substance use disorder rules required certain hospitals and other entities which have substance use disorder records to have a contract protecting such records
  - Possible that this could apply to group health plans and require update to business associate agreements
  - CARES Act (March 2020) modified the rules to make these "Part 2" rules more consistent with HIPAA
  - Expect CARES Act regulations by March 2021, which should provide more detail on what is required

HIPAA Update

- Health plan enrollees have the right to access their medical records (old rule, from 2004)
- Increased enforcement of this rule by Office for Civil Rights
- First-ever enforcement action, followed by flurry of settlements (e.g., 5 in one week in September 2020)
  - Penalties usually modest (e.g., $3,500 - $70,000)
- May want to review BAAs, policies and procedures
- Breach enforcement active as usual
  - Probably higher-risk from a penalty perspective

2021 Preview (and Lame-Duck Considerations)

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General Climate for 2021 (a few thoughts...)

- Coronavirus pandemic with continue to shape many aspects of life
  - Potential increase in telehealth, EAP, mental health and child care benefits
  - Employers could have more shutdowns, layoffs or furloughs
  - Additional federal stimulus action expected, may include COBRA subsidies
  - COVID-19 vaccines – will employers require it?
  - Increase in coronavirus-related litigation
- Cybersecurity/data privacy remain hot topics as many employees continue to work remotely
  - May see more litigation about imposters draining 401(k) accounts
  - DOL guidance expected on cybersecurity issues for plan sponsors and providers
  - More states could enact significant data privacy laws (like California did)
  - Some cases slowly raising the issue of whether plan information is a "plan asset" under ERISA or something that fiduciaries must consider

November – December 2020 Lame-Duck Session

- Will remainder of 2020 bring some changes?
- Prior to election, ongoing negotiations between House Democrats, Senate Republicans and Trump officials
  - Ended up not that far apart (relatively speaking) in October 2020. Many Senate Republicans were ok going to $1.5 trillion; House Democrats passed a $2.2 trillion bill
- Will things change post-election?
  - Senator McConnell: Virus "is not going away until we kill it. So that's job 1" (Nov. 4)
  - Rep. Pelosi: "While we prepare for the new Biden administration, we must also move swiftly for a new coronavirus relief bill" (Nov. 6)
  - Unclear if President Trump will push for new relief, but he had shown some support for it pre-election
- COBRA subsidy unlikely in any bill
- "Surprise" billing possible but may be too complicated

Biden Administration – What to Expect (Cont.)

- Likely to issue an Executive Order to review all proposed regulations and potentially delay effective dates
- Immediate focus on coronavirus and vaccine
  - Could impose more requirements on employers and group health plans
- DOL expected to shift focus to employee protections (instead of pro-employer positions)
  - May impact guidance/enforcement relating to joint-employment, employees vs. independent contractors, gig workers (e.g., Uber, Lyft challenges)
- If Republicans retain control of the Senate (as seems likely), significant changes that require legislation will not work (i.e., tax changes/increases, expanding the Affordable Care Act)
  - Most changes expected through regulation and enforcement efforts

Biden Administration – Policy Changes (Cont.)

- Health Care Vision: "Protect and Build on Obamacare" ("Bidencare"?)
  - Protect the Affordable Care Act (ACA) from continued attacks
  - Support a new public health insurance option like Medicare
  - Increase and extend tax credits to lower premiums
  - Stop "surprise billing"
  - Tackle market concentration across the health care system (lack of competition is driving up prices for consumers)
  - Deal with "abuse" of power by prescription drug corporations
    - Require drug companies to negotiate with Medicare over drug prices
    - Limit launch prices for drugs that face no competition
    - Limit price increases for drugs to inflation
    - Improve the supply of quality generics
  - Expanding access to contraception and protect right to an abortion
  - Defend health care protections for all (including gender identity)

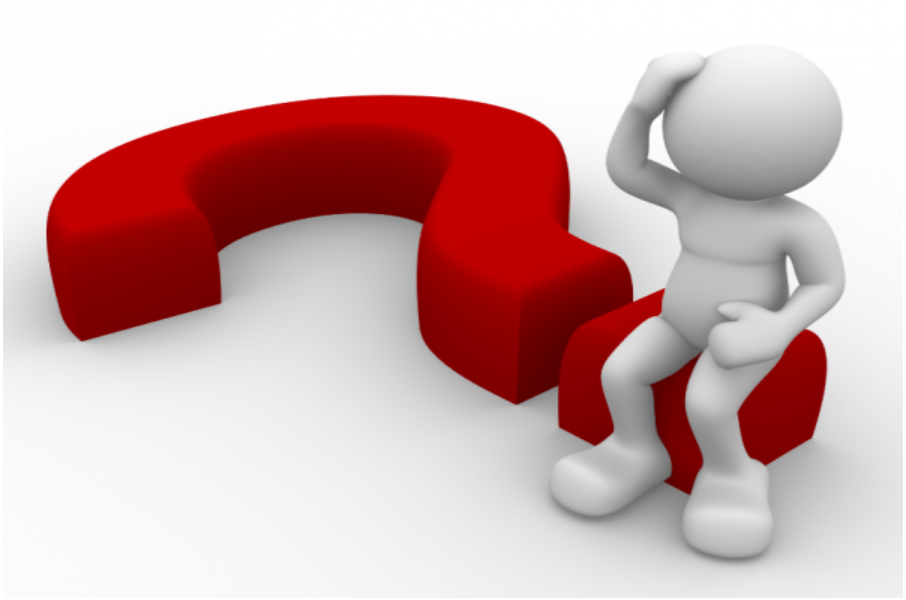
UHC and Electronic Payment Cards

- UHC sent a notice to at least some (all?) of its self-funded employer clients in June 2020 relating to electronic payment cards
- UHC pays at least some out of network providers by paper checks and wants to begin paying them through a "virtual claims payment card"
- UHC's notice states that 1% to 3% of the total transaction amount will be paid to UHC (or a subsidiary)
  - In other words, if $5,000,000 is paid this way in 2021, UHC could keep up to $150,000. It appears that, today, UHC keeps $0 of the $5,000,000. But, of course, you should verify your specific situation (maybe it does save you money)
- For a Quarles & Brady client, asked if there was risk that plan enrollees could be "balance-billed" for that 1% - 3% amount. Or if an employer could be charged for it again
  - E.g., suppose Sally goes to Provider ABC. Sally incurs $1,000 in claims. UHC pays the provider through the payment card. When the provider tries to use it, it seems that the provider could end up with $970, not the full $1,000

UHC and Electronic Payment Cards

- Could Provider ABC balance bill Sally the $30? Could Sally bring a claim (or Sally plus others in the plan bring a class-action lawsuit) against the employer for the $30 (or higher amounts)?
- UHC stated that it has language on each card which may prevent this type of situation
- However, we were unable to convince UHC to specifically indemnify the client for this risk
- Although UHC's June 2020 notice does not state that employers can opt out, based on our discussions we think employers can opt out
  - Client opted out of card payment process
- Consider talking to UHC about it (possible we misunderstood UHC's statements)

Questions



Thank You

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