Show Notes – Benefits Executive Roundtable Legislative & Regulatory Updates, Winter, 2021, Part 2

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Transparency Rule – Health Plans - Overview

- **Public Disclosure**:
  - Must disclosure, to the public, in-network rates, historical out-of-pocket rates, and drug pricing information for plan years beginning on/after **1/1/22**
  - May contract with insurer or third party

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Transparency in Coverage Rule – Digging Into the Details

- Third party administrators and other service providers for the most part are just beginning their implementation process.
- Many TPAs, for example, are just now starting to learn about the rules, so that they can make the determination as to whether they will offer services in-house or subcontract with a vendor.

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Goals and Provisions in the Transparency Final Rule

- ***One of the most important goals of the Transparency Rule is to make consumers more informed on health care spending decisions.***
- In addition, the hope is that ***Transparency reduces the potential for Surprise Billing***
- According to the Final Rule, "making the price of care available to consumers before they receive care can reduce the potential for consumers to be surprised by the price of a health care item or service when they receive the bill after receiving care."
- ***One of the largest concerns is receiving a bill from an out-of-network provider when they thought an in-network provider was treating them.***
  - Called "forced providers"… for example, you have a surgery, you choose the PPO facility and PPO surgeon, but you find out later that your anesthesiologist was non-PPO, or when your doctor sends your lab work out to a PPO lab, who then can't perform that testing and sends it elsewhere, resulting in a non-network lab. Hence, the plan participant had no control; it was a forced provider.
- The hope is that while pricing transparency is not the complete solution alone, the disclosure of pricing directly to consumers could help mitigate some of the unexpected costs.
- Another important hope in this is that by disclosing pricing up front on a public website, consumers can shop, and will of course be drawn to lessor-cost providers; hence, natural competition of providers, which would hopefully drive down costs.

Who Do the Rules Apply To?

- The Transparency Final Rules ***apply to all group health plans and health insurance issuers in the group and individual market, which includes applications to employers who sponsor group health plans.***

- ***Applies to plan sponsor employers as well, even though they generally don't even have access to their health plan's pricing information, assuming they are non-grandfathered under the ACA.***

- In the Final Rules, they specifically discussed how the Departments acknowledged that section 2713 of the PHS Act *requires non-grandfathered group health plans and issuers offering non-grandfathered coverage to provide coverage without cost-sharing* (such as preventive services). However, if the same items or services are furnished for non-preventive services, the participant may be subject to cost-sharing terms of their plans. The Departments stated that the issuer must display the non-preventive cost-sharing liability in the newly required self-service internet tools, along with a statement that the item or service may not be subject to cost sharing if it is billed as a preventive service.

Exemptions

- **Grandfathered Health Plans**
- HRA/HSA Plans
- Excepted Benefits (such as dental and vision plans)
- Healthcare Sharing Ministries
- Short-Term, Limited Duration Insurance (STLDI)

- Grandfathered health plans (those with grandfathered status under the ACA as of March, 2010, are exempt. It's important to note, however, that "Grandmothered" health plans *do* have to comply.
- "Grandfathered health plans are health plans that were in existence as of March 23, 2010, the date of the enactment of PPACA, and that are only subject to certain provisions of PPACA, as long as they maintain their status as grandfathered health plans under the applicable rules. Under section 1251 of PPACA, section 2715A of the PHS Act does not apply to grandfathered health plans. Therefore, the proposed rules would not have applied to grandfathered health plans…"

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7 Content Elements a Plan or Issuer Must Disclose

1. Estimated cost-sharing liability
2. Accumulated amounts
3. Negotiated rates
4. Out-of-Network allowed amounts
5. A list of items and services subject to bundled payment arrangements
6. A notice of prerequisites, if applicable, and
7. A Disclosure Notice

- Generally all 7 are required by an EOB
- Plain language requirement
- Why not just an EOB?
  - Because an EOB won't result in full transparency

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Disclosure Notice

- Such notice requires a complete description of the prerequisites, but also determined that all of that detail would create “unnecessary complexity and impose significant burdens on plans and issuers regarding information that is already available in Plan Documents.” Therefore, they decided it best to require a notice, but with modifications.
- Disclosure notice required that communicates certain information in plain language, including several specific disclosures, including:
  - *a statement that out-of-network providers may bill participants for the difference between providers’ billed charges and the sum of the amount collected from the group health plan* or health insurance issuer and the amount collected from the participant, in the form of cost-sharing (the difference referred to as balance billing), and that these estimates do not account for those potential additional amounts;
  - the *actual charges for the covered items and services may be different than those described in the cost-sharing estimate* (for example, a simple surgery becomes more complicated when they discover additional medical concerns during the procedure, or complications that occur);
  - *a statement that the estimated cost-sharing liability for a covered item or service is not a guarantee of coverage will be provided for those items and services*; and any additional information, including other disclaimers that the plan or issuer determines appropriate, so long as the additional information does not conflict with the information they are required to provide.

In Simpler Terms…

- The *disclosure notice must include information in plain language* that discloses whether the copayment assistance and other third-party payments are included and counts toward deductibles and out-of-pocket maximums (for example, RX copay assistance from the pharmaceutical company is not included), and a statement that the item or service may not be subject to cost-sharing if it is billed as a preventive service (for example, if someone is getting a mammogram but it's actually beyond the preventive services allowed number of mammograms, such as 3 or 4 in a single year).
- To satisfy these requirements, the Departments *created a model notice* that plans and issuers could use, but are not required to use, to satisfy the disclosure notice requirements. A copy of the draft model notice can be found at:

https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-draft-model-disclosure.pdf

- ***I do not recommend use of the Model Notice as it is posted. It would require substantial additional information being added to it!***
- In the disclosure notice, if balance billing is permitted under state law, the Final Rule will not override the state law.

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Website Self-Service Tool for 500 Services and Delivery of Cost-Sharing Information

- Table 1 of the Final Rules contains a list of 500 items and services list. The table includes the Code, Description, and Plan Language Description. This table can be found on page 93 of the Final Rule, at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf
- Keep in mind, this table is much more extensive than the prior hospital requirement to post their "standard charges" for 70 shoppable items as of January 1, 2019. Under the Hospital Price Transparency final rule, hospitals are required to disclose 5 types of standard charges:
  - The gross charge
  - The discounted cash price
  - The payer-specific negotiated charge
  - The de-identified minimum negotiated charge
  - The de-identified maximum negotiated charge
- Health plans and issuers must make cost-sharing information available for the 500 items and services on or after January 1, 2023, and for all items and services for plan years beginning on or after January 1, 2024.
- Plans and issuers must make the required information available, without fees, in two ways….
  1. Through an internet-based "self-service tool" and
  2. In paper form by mail upon a customer's request.

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ACA Section 4980H Compliance & IRS Forms 1094/1095 Reporting

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Forms 1094/1095:
IRS Deadlines for 2020 Forms

Employer Obligation - IRS	Due Date
Furnishing 1095-Cs to Employees	**March 2, 2021** (no further extensions will be granted)
Filing 1094-C and 1095-Cs with the IRS (on paper)	**March 1, 2021** (deadline is moved to the next business day because February 28 falls on a weekend)
Filing 1094-C and 1095-Cs with the IRS (electronically) (required if filing ≥250 1095-Cs)	**March 31, 2021**

- Employers may file a Form 8809 to obtain a 30-day extension to file the forms w/ IRS.
- Small employers that self-fund must file and furnish Forms 1094-B and 1095-B.

- These deadlines also apply to the Forms 1095-B from insurers/HMOs.

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California Minimum Essential Coverage Individual Mandate (S.B. 78)

Employer Obligation - FTB	Due Date
Furnishing Forms 1095 to Employees	**February 1, 2021** (deadline moved to the next business day because January 31 falls on weekend)
Filing Forms 1094 & 1095 with FTB (on paper)	**March 31, 2021**
Filing Forms 1094 & 1095 with FTB (electronically) (required if filing ≥250 Forms 1095)	**March 31, 2021**

- Employers must distribute Forms 1095 to employees; carrier or employer must file Forms 1094/1095 with the FTB ($50/form penalty)
- If filing electronically, **register** in advance w/ MEC IR system
- **Resources**: FTB website; draft Publications 3895B and 3895C

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More State Minimum Essential Coverage Mandates

If you have employees in these states . . .

DC

- Employers must furnish an annual statement to employees (may use IRS form) by IRS deadlines
- Employers with at least 1 employee in the District must file Forms 1095 with Office of Tax and Revenue—both fully insured and self-funded employers—30 days after IRS deadline

MA

- Either the carrier or employer must furnish residents with a Form MA 1099-HC by January 31
- The same data provided in the Form 1099-HC must be filed with the Dept. of Revenue
- Employers must file HIRD data with the Dept. of Revenue

NJ

- Employers must provide the Form 1095-C to residents by March 2
- If the carrier does not file with the Div. of Taxation, employers must file Forms 1095 by March 31; all employers must complete Part III

RI

- Employers or carriers must furnish a Form 1095 to employees by March 2
- Employers or carriers must file Forms 1095 with the Div. of Taxation by March 31; all employers must complete Part III

VT

- While VT has a coverage mandate, it does not appear to have a furnishing and filing requirement, but that will change if the federal rules change

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Forms 1094/1095: Key Changes for 2020

- **Transition Relief**: Insurers/HMOs do not have to mail the Forms 1095-B if they meet two conditions: (i) prominently state on website that notices are available and provide contact information, and (ii) provide notices w/in 30 days of request
- **Transition Relief**: ALEs that self-fund do not have to mail a Form 1095-C to non-FT employees if they satisfy the two requirements noted above for the Form 1095-B
- **Changes to 2020 Form 1095-C**:
  - Plan Start Month: Now required (for everyone)
  - Individual Coverage Health Reimbursement Arrangements (ICHRAs):
    - Codes 1L – 1S added for line 14
    - Line 17 for zip code added
    - Line for "Employee's Age on January 1" added

600120

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2020

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	5 State or province / 6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	10 Contact telephone number
11 City or town	12 State or province / 13 Country and ZIP or foreign postal code

Part II Employee Offer of Coverage — **Employee's Age on January 1** — **Plan Start Month** (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Required Contribution (see instructions)	$	$	$	$	$		$	$	$		$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code													

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2020)

Part III – Where self-insured employers provide information on "Covered Individuals" – has been moved to page 3 of the form.

Grandfathered Health Plan Rules

- On December 11, 2020, the US Departments of Labor, Health & Human Services, and Treasury released the final rule for Grandfathered Health Plans. The final rule amends the requirements for grandfathered group health plans and grandfathered group health insurance coverage to preserve their grandfathered status.
- **Final Rule on Grandfather Plan Status (ACA):** The final rule provides greater flexibility to increase cost-sharing amounts without loss of grandfather status; for example, could increase deductible of HDHP to comply with HSA limits, or could use a new standard for calculating increases in co-pays; applies to plan changes that are effective on/after **6/15/21**

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2015 Final Rules Specify Circumstances Which Changes to Terms Will Cease to be a GF Plan

- The elimination of all or substantially all benefits to diagnose or treat a particular condition
- Any increase in a % cost-sharing requirement (such as co-insurance)
- Any increase in a fixed-amount cost-sharing requirement (other than a co-payment), such as a deductible or OOP Maximum that exceeds certain thresholds
- Any increase in a fixed-amount co-payment that exceeds certain thresholds
- A decrease in contribution rate toward the cost of coverage of any tier of coverage for any class of similarly situated individuals by more than 5%
- The imposition of annual limits on the dollar value of all benefits for group health plans and insurance coverage that did not impose such a limit prior to March 23, 2010

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Amendments to the 2015 Final Rules: HDHP Deductible Limits

- **HDHPs:** An increase to fixed-amount cost-sharing requirements effective on/after 6/15/21 will not cause the plan to relinquish its grandfather status—but only to the extent such increases are necessary to maintain its status as an HDHP under IRC section 223.
  - ***IRS Example***: A GR HDHP had a $2,400 deductible for family coverage on 3/23/10. The plan is amended after 6/15/21 to increase the deductible limit by the amount that is necessary to comply with the requirements for a plan to qualify as an HDHP under section 223(c)(2)(A). This change exceeds the maximum percentage increase under the GR regulations.
  - ***IRS Conclusion***: The increase in the deductible at that time does not cause the plan to cease to be a grandfathered health plan because the increase was necessary for the plan to continue to satisfy the definition of an HDHP under section 223(c)(2)(A).
- **Note:** The annual cost-of-living adjustment to the required minimum deductible for an HDHP has not yet exceeded the maximum percentage increase that would cause an HDHP to lose grandfather status—but it may in the future, causing participants to lose HSA eligibility—and that is the reason for the change in the regulations.

Amendments to the 2015 Final Rules: New Definition of Maximum Percentage Increase

- **Fixed Amount Cost-Sharing**: Under the 2015 rules, there is a formula for plans use to determine if the fixed cost-sharing amount exceeds certain limits; if the plan exceeds the limits, the plan uses GR status;
- The formula relies on the "maximum percentage increase"; under the 2015 rules, the maximum percentage increase is medical inflation from 3/23/10 (tied to CPI-U) plus 15 percentage points
- Under the new rules, on/after 6/15/21, the maximum percentage increase is the greater of (a) the current standard or (b) the change in the premium adjustment percentage plus 15 percentage points
- Why the change? The alternative standard is considered a better reflection of the cost of group coverage

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Amendments to the 2015 Final Rules: New Definition of Maximum Percentage Increase

- ***Example 4.*** *Facts.* On 3/23/10, a GR plan charges a copayment of $30 per office visit for specialists; this is later increased to $40. The plan subsequently increases the $40 copayment requirement to $45 for a later plan year, effective *before* 6/15/21. Within the 12-month period before the $45 copayment takes effect, the greatest value of the overall medical care component of the CPI–U (unadjusted) is 485.
- ***Conclusion.*** The increase in the copayment from $30 to $45, expressed as a percentage, is 50% (45 - 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%). Medical inflation from March 2010 is 0.2527 (485 - 387.142 = 97.858; 97.858 ÷ 387.142 = 0.2527). The increase that would cause a plan to cease to be a GR health plan is the greater of the maximum percentage increase of **40.27%** (0.2527 = 25.27%; 25.27% + 15% = 40.27%), or $6.26 (5 × 0.2527 = $1.26; $1.26 + $5 = $6.26). Because 50% exceeds 40.27% and $15 exceeds $6.26, the change in the copayment at that time causes the plan to cease to be a GR health plan.
- ***Example 5.*** *Facts.* Same facts as *Example 4,* except the GR group health plan increases the copayment to $45, effective *after* 6/15/21. The greatest value of the overall medical care component of the CPI–U (unadjusted) in the preceding 12-month period is still 485. In the calendar year that includes the effective date of the increase, the applicable portion of the premium adjustment percentage is **36%**.
- ***Conclusion.*** In this *Example 5,* the GR health plan may increase the copayment by the greater of: Medical inflation, expressed as a percentage, plus 15 percentage points; or the applicable portion of the premium adjustment percentage for the calendar year that includes the effective date of the increase, plus 15 percentage points. The latter amount is greater because it results in a 51% maximum percentage increase (36% + 15% = 51%) and, as demonstrated in *Example 4*, determining the maximum percentage increase using medical inflation yields a result of 40.27%. The increase in the copayment, expressed as a percentage, is 50% (45 - 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%). Because the 50% increase in the copayment is less than the 51% maximum percentage increase, the change in the copayment requirement at that time does not cause the plan to cease to be a GR health plan.

Note: The percentages used are hypotheticals.

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Plan Limits for 2021

Type of Plan/Limit		2021	2020	2019
HSA Contribution Limits	Self-Only	$3,600	$3,550	$3,500
	Family	$7,200	$7,100	$7,000
HSA Catch-up Contribution	Age 55 or Older	$1,000	$1,000	$1,000
HDHP Minimum Deductibles	Self-Only	$1,400	$1,400	$1,350
	Family	$2,800	$2,800	$2,700
HDHP Maximum Out-of-Pocket Expense Limits	Self-Only	$7,000	$6,900	$6,750
	Family	$14,000	$13,800	$13,500
ACA Maximum Out-of-Pocket Expense Limits	Self-Only	$8,550	$8,150	$7,900
	Family	$17,100	$16,300	$15,800

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More Plan Limits for 2021

Type of Plan/Limit	2021	2020	2019
Health Flexible Spending Account (FSA) Employee Contribution	$2,750	$2,750	$2,700
Health Flexible Spending Account (FSA) Carryover	$550	$550	$500
Dependent Care Spending Account (DCAP)	$5,000	$5,000	$5,000
Transportation Fringe Benefits (Parking/Transit Pass)	$270	$270	$265
Adoption Assistance Program	$14,440	$14,300	$14,080
Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)	$5,300 ($10,700/family)	$5,250 ($10,600/family)	$5,150 ($10,450/family)
Excepted Benefit HRA	$1,800	$1,800	N/A
Educational Assistance Program	$5,250	$5,250	$5,250

Legal Notice

The information provided during this program does not constitute legal advice. In addition, this program only provides a summary of certain complex and always evolving laws and regulations. Attendees/podcast listeners should consult their legal counsel for guidance on the application and implementation of the many federal and state laws that impact employee benefit plans and the workplace, including the topics discussed during this program.

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