PATRIOT GROWTH INSURANCE SERVICES

Compliance News to Know

Noteworthy regulatory changes affecting welfare plans.

News from April 6th – April 20th, 2023: Vol. 2.7

Upcoming Webinar: May 3rd, 1:30 pm EST **Register Here:** Transparency Compliance Reporting

Biden Ends National Emergency Early. Public Health Emergency in Effect Until May 11th.

National Emergency Ended April 10th, 2023; Public Health Emergency Scheduled End: May 11, 2023

President Biden ended the National Emergency (NE) on April 10, 2023, 31 days earlier than previously announced. The Public Health Emergency (PHE) is still in effect until its scheduled end on May 11, 2023.

National Emergency: The Outbreak Period (OP) is 60 days after the end of the NE. Since the NE ends April 10, 2023, the OP will end on June 9th, 2023. On March 29th, the Dept. of Labor (DOL) issued FAQs Part 58, addressing deadline extensions under HIPAA and COBRA. With the earlier NE end-date, deadlines are adjusted.

Deadlines will resume pre-pandemic timeframes as follows: *1 year from the date the participant, beneficiary, or* Group Health Plan *(Plan) was first eligible for relief or 60 days after the announced end of the COVID-19 National Emergency (i.e., 1 year after the date they were first eligible or the end date for the OP), whichever is earlier. In no case will a disregarded period exceed 1 year. All disregarded periods will end as of the last day of the Outbreak Period.* Applicable deadlines are:

1. the 30-day period (or 60-day period, if applicable) to request special enrollment;
2. the 60-day election period for COBRA continuation coverage;
3. the date for making COBRA premium payments;
4. the date for individuals to notify the plan of a qualifying event or determination of disability;
5. the date within which individuals may file a benefit claim under the plan's claims procedure;
6. the date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure;
7. the date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination;
8. the date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete; and
9. the date for providing a COBRA election notice.

Public Health Emergency: Coverage for COVID-19 testing and vaccines remains until the end of the PHE, or May 11, 2023.

- On April 13th, 2023, the Dept. of Health and Human Services (HHS) issued a Notice of Expiration of Certain Notification of Enforcement Discretion.
- Discretion on enforcement will end May 11, 2023, and a 90-day transition period (ending August 9, 2023) for Plans to come into compliance begins for these four enforcement areas:

    1. Permission on Uses and Disclosures of Protected Health Information by Business Associates for Public Health and Health Oversight Activities in Response to COVID–19.
    2. COVID–19 Community-Based Testing Sites (CBTS) During the COVID–19 Nationwide Public Health Emergency.
    3. Online or Web-Based Scheduling Applications for the Scheduling of Individual Appointments for COVID–19 Vaccination During the COVID–19 Nationwide Public Health Emergency.
    4. Telehealth Remote Communications During the COVID–19 Nationwide Public Health Emergency.

Texas Court Vacates Portions of ACA & RFRA in *Braidwood*; Departments Respond with Appeal & FAQs.

Summary: On March 30th, 2023, the U.S. District Court for the Northern District of Texas vacated portions of the Affordable Care Act (ACA) related to certain preventive services. The DOL, HHS, and Dept. of Treasury (the Departments) issued FAQs Part 59 in response to the *Braidwood* decision. Questions from the FAQs are below; for details on responses, view the FAQs.

- The Texas court invalidated only preventive care coverage requirements under the ACA that are based on "A" or "B" recommendations by the United States Preventive Services Task Force (USPSTF).
- The decision also affects Plan sponsors with religious objections to the PrEP HIV medication.
- The decision affect the nation; however, it has been appealed, and we await further updates, including the possibility of a stay while the appeal works its way through the courts.

Background: The ACA was passed in 2010 and requires non-grandfathered Plans and issuers to cover certain preventive services without imposing copay, coinsurance, deductibles, and other cost-sharing requirements. The requirement applies to USPSTF-recommended preventive services with an "A" or "B" rating; recommended immunizations; and preventive care and screenings for women, infants, children, and adolescents per the Health Resources & Services Administration Guidelines.

Immediate Effect: As the ruling is in appeal, Plans may hold off on changes until a final solution is announced, which is likely to take months, including an appeal to the Supreme Court. In the meantime, fully insured Plans are unlikely to change coverage mid-year as such Plans are mandated by each State. Self-insured Plans could alter coverage to implement cost-sharing (citing the *Braidwood* ruling) but doing so would require changing Plan documents and communicating such changes with Plan participants. Any mid-year changes would then be subject to notification requirements established by ERISA. This article outlines a list of USPSTF preventive screening services that could be impacted by the *Braidwood* ruling.

Questions Addressed in FAQs Part 59:

1. Which USPSTF-recommended items and services are affected by the *Braidwood* decision?
2. Are Plans and issuers required* to continue to provide coverage, without cost sharing, for items and services recommended with an "A" or "B" rating by the USPSTF on or after March 23, 2010?
3. Does the *Braidwood* decision affect the requirements* to provide coverage without cost sharing for immunizations recommended by ACIP or preventive care and screenings for infants, children, and adolescents, as well as for women as provided for in comprehensive guidelines supported by HRSA?
4. Does the *Braidwood* decision prevent states from enacting or enforcing state laws that require health insurance issuers offering group or individual health insurance coverage to provide coverage, without cost sharing, for items and services recommended with an "A" or "B" rating by the USPSTF on or after March 23, 2010?
5. To the extent a Plan or issuer is permitted and elects to make changes to its coverage, may it make those changes in the middle of the Plan or policy year?
6. Must Plans and issuers notify participants, beneficiaries, and enrollees if they change the terms of their coverage with respect to USPSTF-recommended items and services that were affected by the *Braidwood* decision?
7. May an HDHP continue to provide benefits for items and services recommended with an "A" or "B" rating by the USPSTF on or after March 23, 2010, before the minimum annual deductible under Code section 223 has been met?
8. How does the *Braidwood* decision affect the requirement under CARES Act section 3203 to cover qualifying coronavirus preventive services?

** PHS Act section 2713*

Who Submits It? Gag Clause Attestation FAQs

Gag Clause Attestation Due: December 31, 2023

Summary: The Departments issued a FAQs document on February 23, 2023. FAQs Part 57 addresses the *Prohibition on Gag Clauses on Price and Quality Information in Provider Agreements*.

Background: Thanks to transparency regulations within the Consolidated Appropriations Act of 2021, certain Plans and issuers will begin the annual attestation that "gag clauses" do not exist within provider agreements.

Question 1: What is a "Gag Clause?"

Answer: *A contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party.*

Question 2: What types of restrictions are impermissible?

Answer: *Restrictions on disclosures of provider-specific costs or quality of care data; electronic access to de-identified claims data; and sharing such data with a BA are not permitted. Note: reasonable restrictions are permitted for public disclosure of data.*

Question 3: How do Plans and issuers submit the attestation?

Answer: *The annual attestation is submitted via CMS' HIOS portal after registration. An overview of the requirement, including an Instruction Guide may be found on CMS' Website.*

Question 4: Who is required to submit the attestation by December 31 of each year beginning 12/31/23?

Answer: *health insurance issuers offering group, individual, student, and association coverages; and fully insured and self-insured Plans, including ERISA plans, non-federal government plans, and church plans. For details about these requirements, review pages 3-5 of the Instruction Guide.*

HIPAA Enforcement Discretion Ends May 11, 2023.

Discretion **expires** at 11:59 pm May 11, 2023

Summary: The Office of Civil Rights (OCR) within HHS is responsible for enforcement of the HIPAA & HITECH Acts. With the expiration of the PHE on May 11, 2023, the enforcement discretion practiced by OCR will expire. However, OCR announced a 90 calendar-day transition period for Plans to comply regarding telehealth services.

Background: From 202-2021, OCR published notification of enforcement discretion to support the public during the pandemic in four areas: COVID-19 testing; how PHI may be used by Business Associates (BAs); telehealth communications; and online scheduling for COVID-19 vaccines.

- HIPAA regulations regarding privacy, security, breach notification, and enforcement were modified to accommodate pandemic needs.
- Respecting telehealth, OCR is providing 90 calendar days for covered health care providers, including Plans, to come into compliance with HIPAA.
- The 90-day period begins May 12, 2023, and runs through 11:59 pm on August 9, 2023.

Employer Application?

- If not in place, Plans must secure BAAs with telehealth providers ASAP and assess processes implemented during the pandemic, then modify as needed.
- Plans should review their remote communication services. If coverage is modified or removed, Plan documentation must be updated. This includes updating the SPD and, if changes are material reductions, sending out a SMM in accordance with timing guidelines.
- Employers should communicate pandemic-ending related deadlines with employees and Plan changes with participants ASAP.

HHS Issues Final Rule re: Benefit & Payment Parameters for 2024.

Click here to review the Final Rule

Summary: HHS issued a **Final Rule**: Notice of Benefit and Payment Parameters for 2024.

- These parameters apply to issuers, Marketplaces, agents, brokers, web-brokers, and Assisters that support consumers using Federally supported Marketplaces for health care enrollment.

Background: The Centers for Medicare & Medicaid Services (CMS) finalized standards established by the ACA to support health care goals of the Biden Administration.

- An outline of policies affected by the Final Rule are listed to the right.
- For details, review the 577-page Final Rule.
- For a summary, view CMS's Fact Sheet instead.

Excerpts from the Fact Sheet:

Special Enrollment Periods.

Eff. January 1, 2024, Marketplaces have the option to implement a new special rule for consumers losing Medicaid or Children's Health Insurance Program (CHIP) coverage that is also considered minimum essential coverage (MEC). Consumers will have up to 90 days after their loss of Medicaid or CHIP coverage to select a plan for Marketplace. This change aligns the Medicaid or CHIP SEP period with the 90-day Medicaid or CHIP reconsideration period without having to resubmit a new application with their State Medicaid Agency.

Provisions Related to Agents, Brokers, or Web-brokers.

CMS finalizes a requirement that agents, brokers, and web-brokers document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or the consumer's authorized representative prior to application submission.

CMS also requires the receipt of consent from the consumer or the consumer's authorized representative prior to providing assistance. Such documentation must be retained by the agent, broker, or web-broker for a minimum 10 years, and be produced upon request in response to monitoring, audit, and enforcement activities.

Policies Affected by the 2024 Parameters:

- **Increasing Access to Health Care Services**
  - Network Adequacy & Essential Community Providers
- **Simplifying Choice & Improving the Plan Selection Process**
  - Standardized Plan Options
  - Non-Standardized Plan Option Limits
  - Stand-Alone Dental Plans (SADPs)
  - Re-enrollment Hierarchy
  - Establish Requirements for Qualified Health Plan and Plan Variant Marketing Names
- **Making it Easier to Enroll in Coverage**
  - **Special Enrollment Periods**
  - Income Data Matching Issues
  - Allow Door-to-Door Enrollment by Navigators and Other Assisters
  - Failure to File and Reconcile Process
- **Strengthening Markets**
  - FFM and SBM-FP User Fees
  - HHS-Operated Risk Adjustment Program
  - HHS Risk Adjustment Data Validation
  - Premium Adjustment Percentage and Payment Parameters
- **Bolstering Program Integrity**
  - Establish Improper Payment Pre-Testing and Assessment for State Marketplaces
  - **Provisions Related to Agents, Brokers, or Web-brokers.**