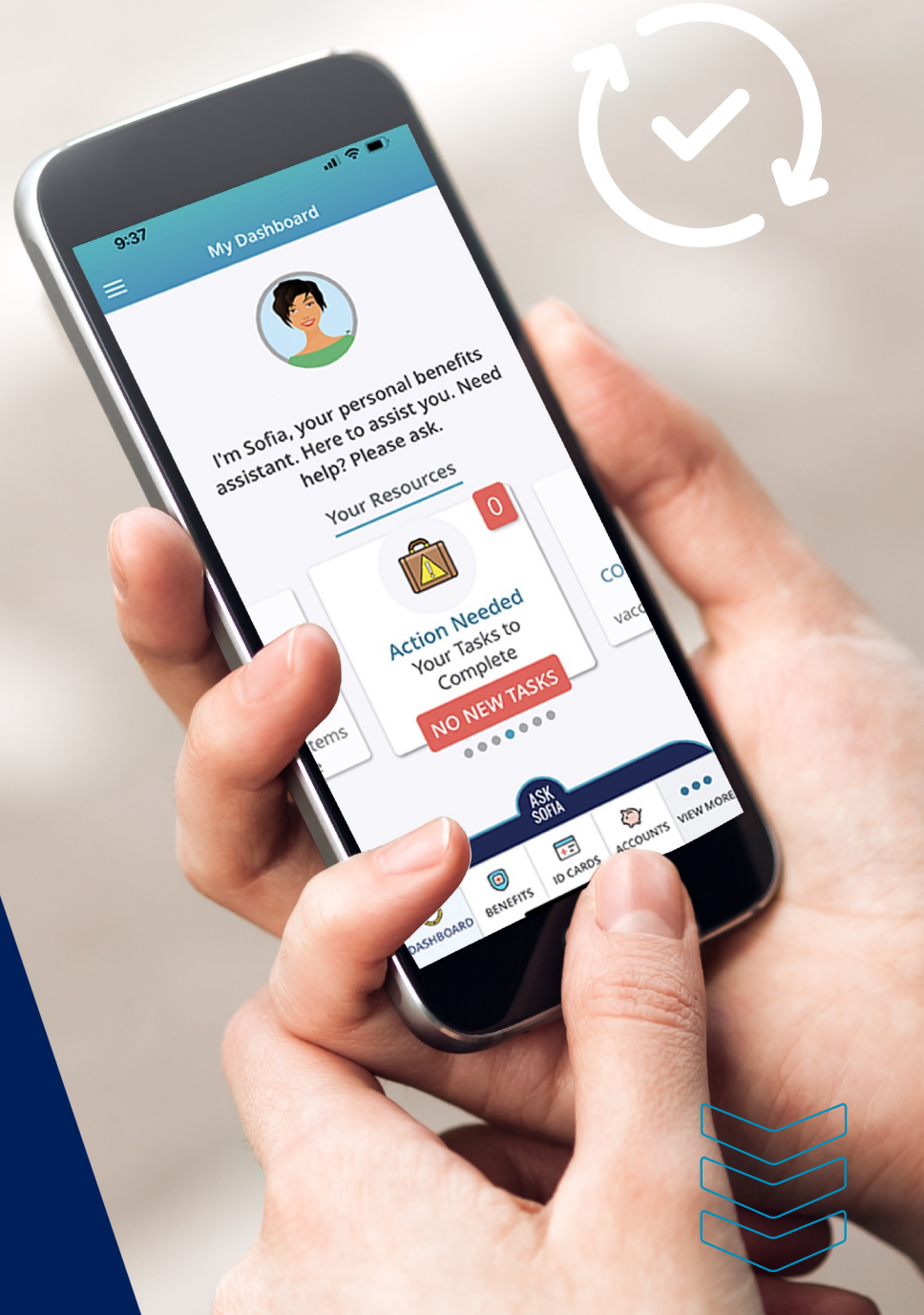
Compliance Update

Dec. 19, 2023



Compliance Outlook

2023 in Review
What's Coming for 2024

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Expiration of the Pandemic Public Health Emergency & National State of Emergency

Learnings and Deadlines

PHE Ended May 11, 2023
No longer covered: COVID-19 testing and vaccinations

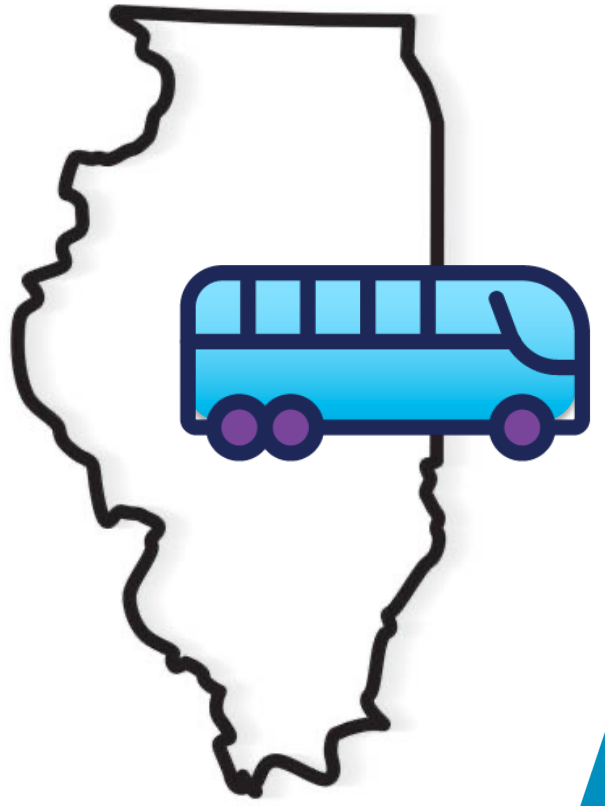
National State of Emergency ended April 10
Note: any additional run-out periods for FSAs, COBRA impacts
Outbreak Period: 60 days after end of emergency

Details
CMS FAQ

Illinois Commuter Pre-tax Benefit Requirement

Promoting commuter benefits for public transportation

- The new Illinois Transportation Benefits Program Act (HB 2068; P.A. 103-291) aims to promote the commuter benefits available to employees who use public transportation to commute to and from work.
- Beginning January 1, 2024, certain employers located within designated Illinois counties and townships will be required to provide employees a “pre-tax commuter benefit.”
- To qualify for the benefit, an employee must average at least 35 hours of work per week. For newly hired employees, the benefit begins on the first full pay period after 120 days of employment.



Action Item: If you have employees in Illinois–review these requirements to determine if your employee populations obligate you to meet this requirement based on their home address.

Need a list of all commuter mandate locations? Check out this blog.

First Gag Clause Attestations Due From Group Health Plans by December 31

Submit your attestation electronically

The Consolidated Appropriations Act, 2021 (CAA), requires group health plans and insurers to annually attest they compliant with the gag clause prohibition under the CAA. **The first attestation is due no later than December 31, 2023**, and covers the period from the date of the enactment of the CAA on December 27, 2020, through the date of the attestation. Future attestations will be due each subsequent December 31 and will cover the period since the last attestation was completed.

How do plans make the attestation?

The attestations are all done electronically on the Centers for Medicare & Medicaid Services (CMS) website. A link to the attestation, along with a set of FAQs, instructions, and a user manual for submitting the attestation, can be found on CMS's website under Resources.

Action Item: Ensure your group health plan is prepared to meet the December 31, 2023, deadline.

Requirements Related to the Mental Health Parity and Addiction Equity Act (1/2)

The Mental Health Parity and Addiction Equity Act's (MHPAEA) proposed regulations establish a formal structure for how the Departments will enforce the requirement that plans and issuers comply with their obligations to provide a nonquantitative treatment limitation (NQTL) analysis on request.

Requirements Related to the Mental Health Parity and Addiction Equity Act (2/2)

The recent guidance from The Departments regarding MHPAEA does several things:

1. Makes clear that MHPAEA requires that individuals can access their Mental Health (MH)/Substance Use Disorder (SUD) benefits in parity with Medical (M)/Surgical (S) benefits.

2. Makes clear that plans and issuers cannot use more restrictive prior authorization and other medical management techniques (i.e., NQTLs) for MH/SUD benefits, standards related to network composition for MH/SUD benefits and factors to determine out-of-network reimbursement rates for MH/SUD care providers.

3. Requires plans and issuers to collect and evaluate outcomes data and take action to address material differences in access to MH/SUD compared with M/S benefits.

4. Codifies the requirement that plans and issuers conduct meaningful comparative analyses to measure the impact of NQTLs. This includes evaluating standards related to network composition, out-of-network reimbursement rates and prior authorization NQTLs.

Action Items:

1. Keep this on your radar. While not finalized, employers should keep an eye on this, as you are presently subject to the comparative analysis requirements.
2. Evaluate your current Non-quantitative Treatment Limitations against the proposed rule and work with appropriate plan design counsel to determine if any changes are needed.
3. Read the proposed rules for more information.

Awareness: Class Action Suits

Health & Welfare Plan Administrators

Now that federal regulators are focused on fee and pricing transparency for health plans, there is a new litigation push against health plan fiduciaries.

Signaling his intentions, one lawyer has observed that “[t]he fiduciary duty for a healthcare plan sponsor is essentially the same duty as a retirement plan sponsor of a 401(k) or 403(b).”

His law firm has begun posting advertisements on its LinkedIn page seeking potential employee plaintiffs regarding health plans sponsored by Target, State Farm, and PetSmart.

More details

CMS Coverage and Access

The Departments sought public input on on how best to ensure coverage and access to over-the-counter (OTC) preventive services. Comment time has passed.

The services being considered include **contraception, tobacco cessation, and breastfeeding supplies.**

Related press release for information

Fixed Indemnity Policies

The DOL, HHS, and IRS have jointly proposed regulations that would limit the permissible duration of short-term, limited-duration health insurance (STLDI).

The proposals would also modify the conditions for certain fixed indemnity insurance to be considered an excepted benefit and clarify the tax treatment of certain benefit payments in fixed amounts received under employer-provided accident and health plans.

Learn more

Awareness: ACA Electronic Filing

For organizations that **don't use BSC** or service for ACA filing:

Beginning in 2024, encompassing the 2023 reporting year, employers who are filing a total of **10 or more returns** are obligated to electronically submit their Forms 1094-C and 1095-C.

Mandatory Insurer Reporting for Non-Group Health Plans

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) **added mandatory reporting requirements** with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation, collectively referred to as Non-Group Health Plan (NGHP) or NGHP insurance.

The purpose of Section 111 reporting is to enable CMS to pay appropriately for Medicare-covered items and services furnished to Medicare beneficiaries.

Learn more

REMINDER: Non-Discrimination Testing

Consider completing this **in Q2** each year to allow time to process and update according to test results.

REMINDER: Consumer Account Limits for 2024

Healthcare and Limited Purpose FSA	$3,200
Maximum carryover amount of unused FSA amounts	$640
Monthly limit for commuter: transit and parking	$315/month
Maximum exclusion for Qualified Adoption Expenses	$16,810
Dependent Care FSA	No change; $5,000/filing jointly or $2,500/filing separately
HSA	Individual: $4,150 Family: $8,300 Age 55+ catch-up contribution: +$1,000

Questions?

CREDITS

HRCI Program ID: 647898

SHRM Activity ID: 23-G4VUT

Program ID: 647898 **Activity ID: 23-G4VUT**

Thank you!

Have a wonderful holiday season.

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