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The Most Important Changes About ACA for 2023 What You Need to Know

[Employee Benefits Compliance Update]

Bob Radecki

Senior Regulatory and Public Policy Analyst

Benefit Comply

Employee Benefit Compliance Support

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Submit your questions anytime. We'll do Q&A at the end.

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Speaker

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Agenda

- An update on health cost transparency rules
- The reduction in the ACA affordability % to 9.12% will require some employers to modify contribution arrangements to avoid penalties
- The new IRS definition of employer plan affordability for family coverage
- Prepare for the end of the special rules related to the National Health Emergency and the associated Outbreak Period
- Employer reporting and the end of IRS good faith relief for reporting errors
- Other breaking legislative and regulatory changes

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Health Cost Transparency Update

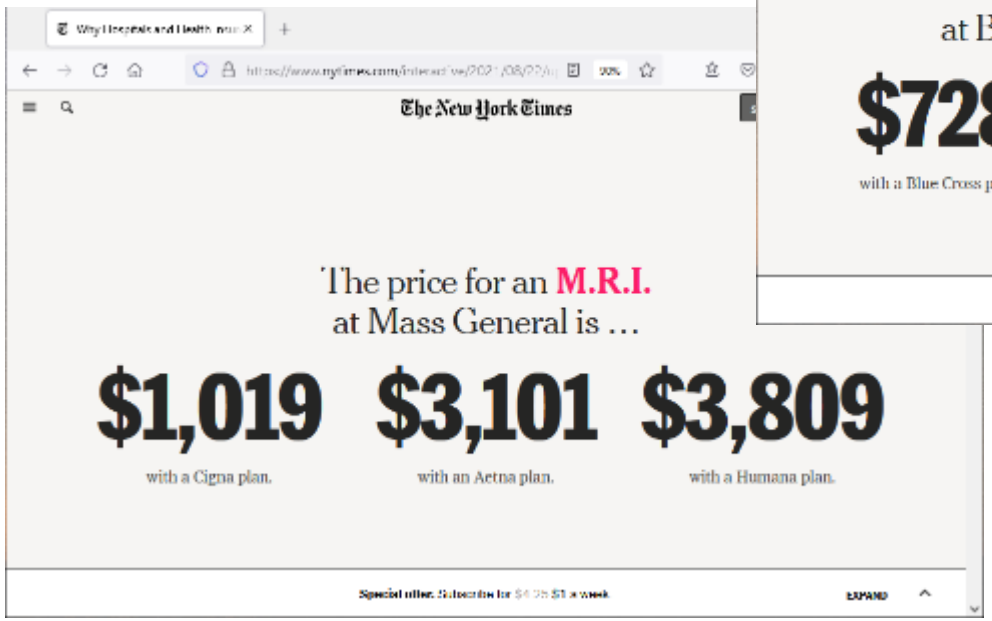
Hospital Cost Reporting

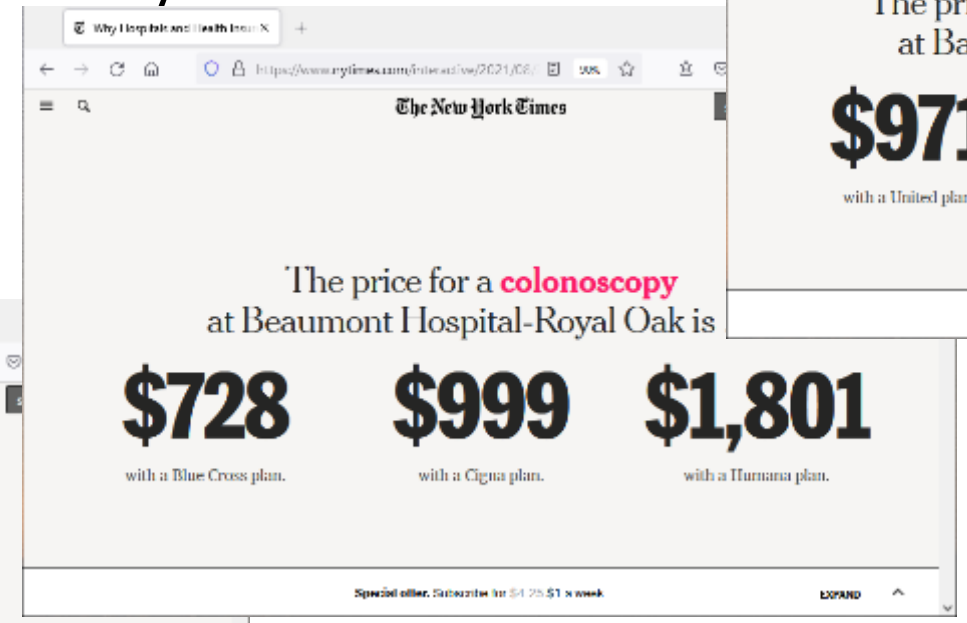
Requirement Basics – Effective 1/1/2021

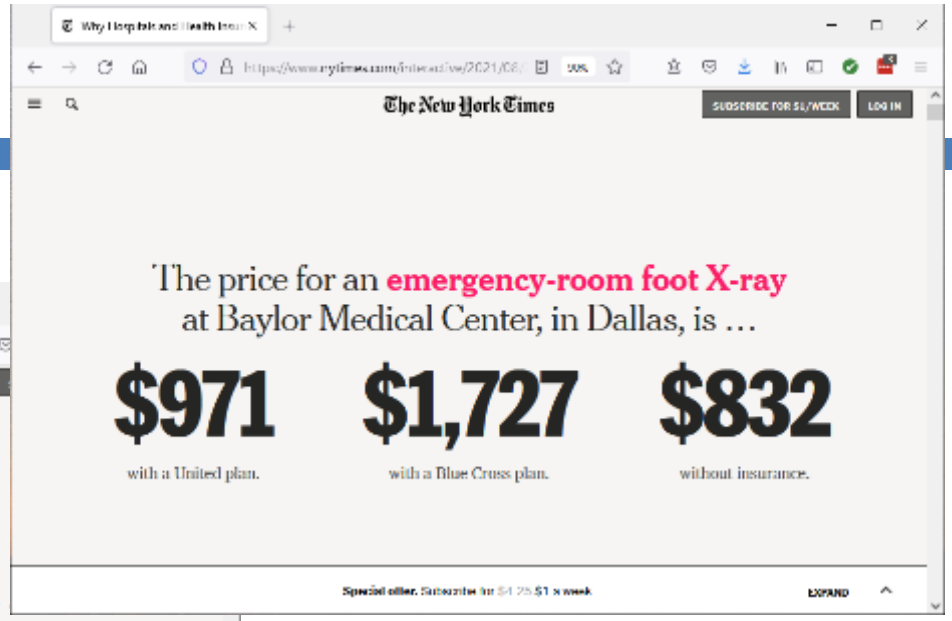
- Hospitals must publish a machine-readable file containing these types of charges for all “items and services” provided by the hospital
  - Gross charges - The non-discounted rate, as reflected in a hospital’s chargemaster
  - Discounted cash prices - The rate the hospital would charge individuals who pay cash
  - Payer-specific negotiated charges - The rate hospital has negotiated with a third-party payer
  - De-identified minimum negotiated rates - The lowest and highest rates that a hospital has negotiated with all third-party payers without identifying the payer
- Hospitals must publish list of hospital’s 300 most “shoppable services”
  - CMS listed 70 shoppable services that must be included; hospital selects the remaining 230
- Required Reading!
  - Health Affairs - Low Compliance From Big Hospitals On CMS’s Hospital Price Transparency Rule
  - New York Times - Hospitals and Insurers Didn’t Want You to See These Prices. Here’s Why – Aug. 22, 2021

Hospital Cost Reporting

Differences Between Different Payers







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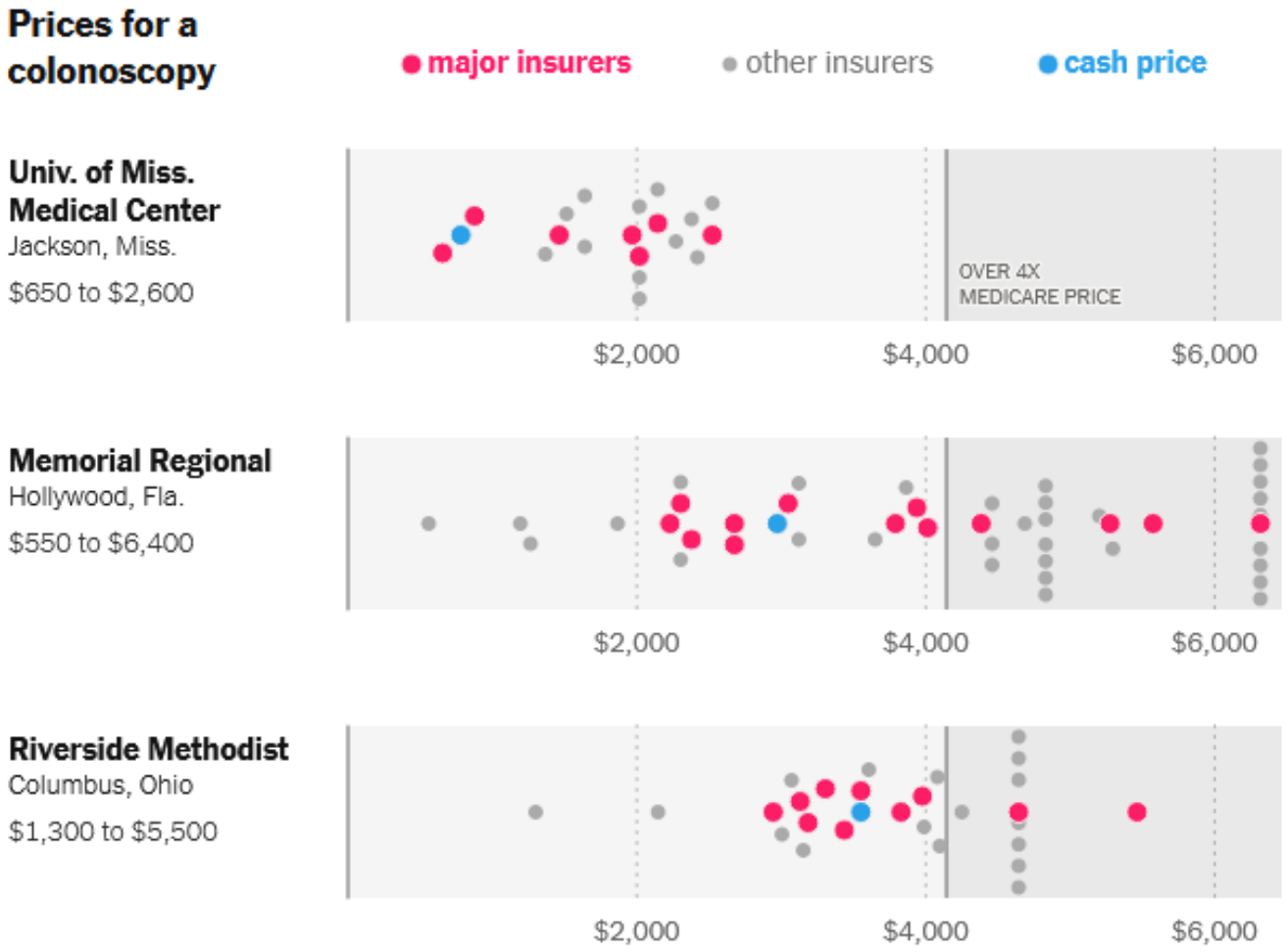
Hospital Cost Reporting

At multiple hospitals, major health plans pay more than four times the Medicare rate for a routine colonoscopy.



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Health Plan Cost Transparency - Phase 1

Publicly Post Plan Cost Data in a Machine-Readable File

The Machine-Readable Files

Pricing Data Disclosure – The Machine-Readable Files

- Effective July 1, 2022 - Plans & insurers must publicly post machine-readable cost files and update monthly
  - The In-Network Rate File
    - All applicable rates with in-network providers for all covered items and services (including negotiated rates, underlying fee schedules, or derived amounts)
  - The Allowed Amount File
    - One on billed charges and allowed amounts for out-of-network providers
  - The Prescription Drug File - Enforcement delayed indefinitely
- Does not apply to grandfathered plans, account-based plans (HRA/FSA), or excepted benefits (dental, vision, etc.)
- This has nothing to do with employees - so no employee notification is necessary

The Machine-Readable Files

Do employers need to post a link?

- Departments (DOL, IRS, HHS) Guidance Released August 19th
- https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf
- Employers do not need to post link to files on the employer's company website
  - Posting only required if employer maintains a public website for the employer's group health plan
  - Most employers do not maintain a public website for their plan
  - An intranet site available only to employees or participants is not a public website

Good News!

Bottom Line:

Employers are not required to post links to machine readable files so long as they have a written agreement with carrier or TPA to post the files relevant to their plan.

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The Machine-Readable Files

- Employers should have “written agreement” with carrier or TPA to publicly post the relevant data files
  - Fully-insured plans – If files are not posted, the carrier is liable
  - Self-insured plans – If TPA does not post files, employer/plan sponsor is liable
- What is a “written agreement?” – no guidance provided…

Great → Specific MRF language in group contract or administrative service agreement

Good → Send an email to vendor asking for confirmation of posting and receive a specific response

Probably OK → Receive something in writing (email, letter, etc.) from carrier or TPA stating they will make relevant files publicly available

Maybe OK → Already have more general language in group contract or administrative service agreement regarding carrier or TPA compliance with applicable laws and regulations

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Health Plan Cost Transparency - Phase 2

Prescription Drug Cost Reporting

Rx Cost Reporting

Rx Cost Reporting Required Annually

- Collects data on drug costs to be used by the federal government and businesses to lower drug costs
- Federal government will issue an annual report on Rx costs
- Data for 2020 & 2021 must be submitted by December 27, 2022
- Future reporting must be submitted by June 1 after the end of the calendar year
- Data Examples
  - Total Rx spending
  - Total spending by the plan by types of cost (e.g., hospital, primary care, specialty care, prescription drugs)
  - 50 most common brand prescription drugs paid by the plan and total claims paid for each of the 50 most costly drugs by total annual spending and the annual amount spent for each
  - Average monthly premiums paid by the employer and the participants
  - Rebates and PBM fees
  - And More

Rx Cost Reporting – The Process

- Employers will need to rely on, and work with, vendors to complete reporting…

"Reporting Entities" must set up account in CMS HIOS system

- Multiple entities may report for a single plan (e.g., TPA, PBM, employer)

Submit a plan file, 9 separate data files, and narratives

- Employer must determine who has the necessary data and ensure plan files are submitted

Confirm submissions

- No way to confirm in CMS system, so employer will need to get confirmation from vendors that data is reported

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Reporting Responsibility

Most employers will rely on vendors to do some, or all, of the reporting – however – some self-insured employers may need to do some of the reporting themselves

- The organization submitting the data is referred to as the “Reporting Entity”
  - There may be multiple reporting entities for an employer's plan (TPA, PBM, Employer)
- Most vendors will be submitting aggregate files data that includes data for all of their employer clients – not plan-specific employer plan data

Employer Responsibility By Type of Plans Offered

- Employer Type 1 – Fully-Insured
  - Health Plan is fully-insured and all Rx claims are paid by the carrier
    - Subgroup A – In most cases the employer can rely on the carrier to submit all required reports
    - Subgroup B – A small number of carriers will file most of the data but are telling the employer to file the D1 file (Premium & Life Years) and accompanying P2 file
- Employer Type 2 – Self-Insured With Integrated Vendor
  - Health plan is self-funded – employer uses TPA and its affiliated PBM to handle prescription drugs – medical and Rx claims data are paid by integrated vendor
    - Subgroup A – In many cases, the employer will be able to rely on the TPA to submit all required reports
    - Subgroup B –Some TPAs will file most of the substantive files (e.g. D2- D8) but expect the employer to file one or more files
      - Most commonly the D1 file (Premium & Life Years) and accompanying P2 file

Employer Responsibility By Type of Plans Offered

- Employer Type 3 – Self-Insured with Separate, Multiple, or Carve-out Vendors
  - Health plan is self-funded but has one or more vendors who handle drug claims separate from the medical TPA (e.g. TPA with a carve-out PBM, integrated TPA/PBM but separate specialty drug program, etc.)
    - The employer will need to work with the TPA and each drug vendor separately to complete the filing
    - Communicate with each vendor to make sure that vendor is submitting the reports that vendor is responsible for
      - A common scenario would be the TPA submits the D1 and D2 files and the PBM submits the D3-D8 files
      - The vendors may also require the employer to submit certain files itself, e.g., the D1 file and accompanying P2 file

Resources

- CMS Rx Reporting Page (Instructions & Templates)
  https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection
- CMS FAQs
  https://regtap.cms.gov/uploads/library/faq-tracker-20220922-5CR.pdf
- HIOS Portal User Manual
  https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-Portal-User-Manual.pdf
- HIOS Quick Reference Guide
  https://regtap.cms.gov/uploads/library/HIOS-Portal-RxDC-Quick-Guide-09-06-2022.pdf

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Health Plan Cost Transparency - Phase 3

Make Price Comparison Tool Available to Participants

Advanced Cost Estimate “Price Comparison Tools”

- Plans and insurers must disclose estimates of cost-sharing for covered services from a particular provider.
  - Disclosure must be available by “web tool” and telephone - paper option offered when requested
- Effective Dates:
  - 500 items & services January 2023 - all items and services January 2024
- Many carriers & TPAs already offer pricing tools but will need upgrades
- Compliance Responsibility
  - Fully-insured plans can rely on their carrier
  - Self-insured plans are technically liable for the compliance of their plan but can contract with TPA, administrator, or network to offer the pricing tool

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Sometime In the Future

Provider Good Faith Estimate & Advanced EOB

Provider Good Faith Estimate & Advance EOB

- Effective Date - TBD
  - Delayed Pending Further Guidance
- Provider Estimate
  - Medical providers must provide patients with good faith estimate of expected costs at time care is requested or scheduled
  - Information must be sent to the patient's health plan
- Advanced EOB
  - Payer will then produce an "Advanced EOB"
  - Includes estimate of participants out-of-pocket expenses based on provider cost estimate, plan benefits, and participants current cost sharing

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Affordability and the Family Glitch

2023 §4980H Affordability Percentage

- IRS decreased §4980H affordability percentage from 9.61% (2022) to 9.12% (2023)
  - Effective for plan years beginning on or after January 1, 2022

Affordability Percentage	2015	2016	2017	2018	2019	2020	2021	2022	**2023**
	9.56%	9.66%	9.69%	9.56%	9.86%	9.78%	9.83%	9.61%	**9.12%**

  - The decrease in the affordability % may require employers to lower employee contributions for 2023 plan year to meet the affordability requirements under §4980H(b)
    - W-2 Salary Safe Harbor example:

	2022	**2023**
W-2 Salary	$25,000.00	$25,000.00
	9.61%	9.12%
	$2,402.50	$2,280.00
Affordable Monthly Employee Contribution	**$200.21**	**$190.00**

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Change to "Family Glitch"

- IRS has changed the definition of affordability for the purpose of qualification for premium tax credits

Current Affordability Rule

- Affordable for employee and all eligible family members if **single coverage is affordable**
- Employee contribution for single coverage cannot exceed 9.61% (in 2022) of household income

New Affordability Rule

- Affordability for employee based on employee contribution for single coverage (cannot exceed 9.61% of household income)
- **Affordability for family members based on employee contribution for family coverage** (cannot exceed 9.61% of household income)

Employer will not be penalized for unaffordable family coverage

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Affordability New Rule – Some Details

- No employer penalties for unaffordable family coverage
- No change to employer reporting requirements
- No specific employee notice or disclosure requirements

  Exchange notice and COBRA notices may need to be updated
- Effective for Exchange enrollments beginning January 1, 2023 – Open enrollment on Healthcare.gov started Nov. 1
  - Covered California Open enrollment runs from Nov. 1, 2022 – Jan. 31, 2023
- IRS issued a new Section 125 rule that allows employees to drop family coverage if family is moving to the Exchange

Inflation Reduction Act

- Significant Increase in Subsidies Extended Through 2025

Income (% of poverty)	**Affordable Care Act** (before legislative change)	**COVID-19 Relief (current law 2021-2022)**
Under 100%	Not eligible for s	Not eligible for subsidies**
100% – 138%	2.07%	0.0%
138% – 150%	3.10% – 4.14%	0.0%
150% – 200%	4.14% – 6.52%	0.0% – 2.0%
200% – 250%	6.52% – 8.33%	2.0% – 4.0%
250% – 300%	8.33% – 9.83%	4.0% – 6.0%
300% – 400%	9.83%	6.0% – 8.5%
Over 400%	Not eligible for subsidies	8.5%

Extended Through 2025

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Inflation Reduction Act

- Impact of Subsidy Increase

Annual Household Income	Family Size	% FPL	Average "Retail" Monthly Prem.	Subsidized Silver Plan Mo. Prem.
$20,000	1	157%	$353	$5
$20,000	4	76%	Medicaid	Medicaid
$40,000	1	313%	$353	$211
$40,000	4	153%	$1,245	$4
$60,000	1	470%	$353	$353
$60,000	4	229%	$1,245	**$158**
$80,000	4	305%	$1,245	**$409**
$125,000	4	477%	$1,245	**$885**

- Silver Plan Cost (approx. $3,000 deductible plan - OOP reduced for lower income)

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Possible End to National Emergency and Outbreak Period Rules

Public Health Emergency & National Emergency

- COVID-19 National Emergency up for renewal in February 2023
- There are two different kinds of pandemic-related “Emergencies”

Public Health Emergency	National Emergency
Declared by Department of Health and Human Services (HHS) beginning in January 2020 and extended multiple times - Each extension lasts three months.	First declared by President Trump in March 2020 - Remains in force until declared over by President. “Outbreak Period” = End of National Emergency + 60 days.
Group health plans required to cover COVID-19 diagnostic testing and vaccinations and related services, including out-of-network	COBRA notice, HIPAA special enrollment notice, and ERISA claims filing deadlines are all delayed for one year from the original deadline applicable to any participant or until the end of the outbreak period (TBD)

National Emergency and Outbreak Period

- COBRA notice, HIPAA special enrollment notice, and ERISA claims filing deadlines are delayed for one year (the “disregarded period") or until the end of the Outbreak Period (TBD)
  - Disregarded Period
    - Outbreak Period (National Emergency + 60 days) or 1 year from the individual’s original deadline (whichever expires first)
    - Applies to the following deadlines:
      - Notice for requesting HIPAA special enrollment rights
      - ERISA claims filing deadlines (including health FSA and HRA run-out periods)
      - COBRA elections and payments
- If National Emergency Ends in February
  - Adjustments to any change made to notices (COBRA, HIPAA Special Enrollment, etc.)
  - Need guidance from regulators on what to do with participants in current “extended periods”

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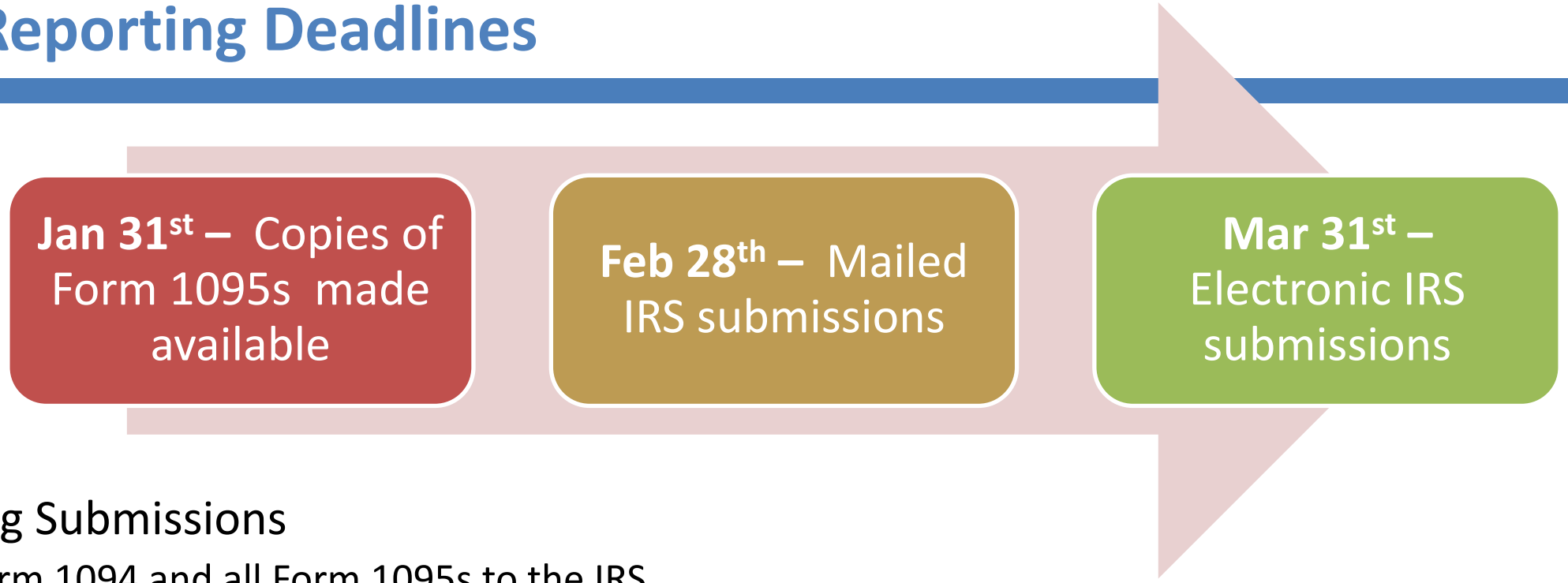
Employer Reporting

Employer Reporting Deadlines



- IRS Reporting Submissions
  - Submit Form 1094 and all Form 1095s to the IRS
  - Employers filing 250 or more Form 1095s must submit forms electronically
- Copies to Individuals
  - Provide copies of Form 1095s to full-time employees and covered individuals
  - Forms may be delivered by hand, mail, or electronically if consent is given

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State Individual Mandate Reporting

- State Individual Mandates

  California, Massachusetts, New Jersey, Rhode Island, Washington D.C.

	Required Forms	Reporting Deadlines
California	Form 1094 and Form 1095s	• Statements to covered individuals due January 31st • Filing with FTB due March 31st
Massachusetts	Form 1099-HC	• Statements to covered individuals due January 31st • Filing with DOR due March 31st
New Jersey	Form 1094 and Form 1095s	• Statements to covered individuals due March 2nd • Filing with DORES due March 31st
Rhode Island	Form 1094 and Form 1095s	• Statements to covered individuals due January 31st • Filing with DOT due March 31st
Washington D.C.	Form 1094 and Form 1095s	• Statements to covered individuals due January 31st • Filing with OTB due 30 days after federal reporting

Reporting Penalties

- No More Good Faith Relief
  - Through 2020, IRS provided relief from the reporting penalties for failing to provide complete, correct information if it was clear that the employer made a good faith effort to report and submitted the reporting on a timely basis
  - Beginning with the 2021 reporting, this good faith relief is no longer available
  - Employers should be extra careful in reviewing and approving submissions to the IRS to make sure the reporting is as complete and accurate as possible

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Other Regulatory and Legislative Issues

Telemedicine and HSA Eligibility

- CARES Act Telemedicine HSA Eligibility Relief
  - Beginning in March 2020 - Employers allowed to offer telemedicine with coverage before participants have met the applicable minimum deductible, without jeopardizing the employee's eligibility to make HSA contributions
  - This HSA safe harbor expired for plan years beginning 1/1/2022
- Relief in Consolidated Appropriations Act 2022 signed March 15, 2022
  - Telemedicine again disregarded for purposed of HSA eligibility through December 31, 2022

If Congress does not extend relief soon - telemedicine benefits (that provide coverage for more than preventive care before minimum HSA deductible) will once again make an individual ineligible for HSA contributions

Any Questions?

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THANK YOU!

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