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EMPLOYEE BENEFITS

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Whew! The Year-End Rush is Over. What do you need to know for 2023?

2023 is here – are we back to normal yet?

The year that just ended would have been unprecedented, but it was preceded by 2021 and 2020! Human Resources and Employee Benefits professionals were still scrambling to implement the last of the pandemic protocols and incorporate the temporary measures that were mandated for employer-sponsored group medical plans. The final temporary measures will *mostly* have expired by the end of 2022.

The Biden Administration has recently announced that both the National and Public Health Emergencies will terminate as of May 11, 2023. Some measures employers hoped to be permanent, such as the expansion of the flexibility around the use of telemedicine, were only partially and temporarily extended. Other provisions, such as the extension of paid leave mandates in various state and local jurisdictions, have become permanent.

Finally, 2022 saw the full incorporation of other new laws and regulations including the expansion of the mental health parity rules, new transparency obligations and no surprises requirements that will apply to employer plans. Their full implementation is likely to be felt in 2023.

Unfortunately, then, we are not quite back to normal yet. While many complexities have subsided, some continue for the time being and, of course, others have come to occupy the space left behind. **What are the key items employers should be looking for as we prepare for 2023 and plan for 2024 open enrollment?**

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World Observation

Most employers rely on their carriers and other vendors to comply with ERISA and other laws. However, even if those vendors do take on the administrative obligations on behalf of the employers, the employers are still ultimately responsible for the requirements. Therefore, employers need to be vigilant with respect to their vendors and monitor their activities on behalf of the employer and the employer plan.

Ongoing deadlines, plus a new one

Every employer plan has multiple deadlines to contend with (See the WIA Compliance Calendar here). The link has the full WIA Compliance Calendar, and we recommend it for your ongoing use. The highlights (based on plans with calendar year plan years, plans that have off-calendar plan years would adjust the requirements accordingly – except as noted) are summarized below:

First Quarter

Date	Requirement
January 31	*New requirement, regardless of plan year* First drug cost reporting requirement to CMS for 2020 and 2021
February 28	*March 31, if filing electronically* *Applies to all plans regardless of plan year* Applicable Large Employers (ALEs) File forms 1095 and 1094 with IRS
March 1	File Medicare Part D disclosure with CMS
March 2	ALEs send forms 1095-C and/or 1095-B to all full-time employees (Non-ALEs with self-funded plans send to covered employees)

Second Quarter

Date	Requirement
June 1	*Regardless of plan year* Drug cost reporting information to CMS

Third Quarter

Date	Item
July 31	*Regardless of plan year* File IRS Form 720 and pay PCORI fee Employers with 100 or more participants file 5500 with DOL
September 30	*Regardless of plan year* Deadline to receive Medical Loss Ratio (MLR) rebates if generated. Employers with plans that receive a rebate must determine the appropriate share and method to return to participants Send Summary Annual Report *(if employer has a 5500 obligation)*

Fourth Quarter

Date	Item
October 31	Send Medicare Part D notices of Creditable Coverage to eligible individuals *(if plans provide prescription drug coverage)*

Ongoing Extension Set to Expire on May 11, 2023

Last spring, President Biden extended the COVID-19 National Emergency for another year, and separately his administration permitted ongoing extensions of the Public Health Emergency. In January, the President announced that both the NE and the PHE would expire on May 11, 2023. That means that the health plan mandates affected by the PHE will continue to run until May 11. The primary impact of that mandate's expiration is that plans will no longer be forced to pay for COVID testing with no out-of-pocket cost and will not have to limit the cost for OTC COVID testing. COVID vaccinations must continue to be paid for with zero out-of-pocket cost as a preventive care item that was added to the list for all ACA-compliant healthcare plans.

Additionally, certain plan deadline time extensions (see below) will continue to run until the end of the "outbreak period" (which will end on July 10, 2023, 60 days after the end of the NE). That continues to provide plans and plan participants additional time to meet those plan deadlines. The primary deadline that might affect plans is the general COBRA election period. COBRA qualified

beneficiaries will have their normal 60 days to elect COBRA (and the additional time to make their premium payments – 45 days for the first one and 30 days thereafter) plus any remaining time in the outbreak period. Since qualified beneficiaries will have, potentially, more than the normal 60 days to make elections (and 45 or 30 days to make payments) plan administrators need to be aware of those potential COBRA elections and payments that may have to be honored by the plan despite being "late."

Deadlines affected by extension of the NE:

COBRA Qualifying Event and Disability Extension Notices – Qualified beneficiaries have 60 days to notify the plan of certain qualifying events (e.g., divorce or legal separation, a dependent child ceasing to be a dependent under the terms of the plan) or disability determination.

COBRA Election – The 60-day deadline to elect COBRA continuation coverage.

COBRA Premium Payments – The 45-day (for the initial payment) and 30-day (for subsequent payments) deadlines to timely pay COBRA premiums.

HIPAA Special Enrollment Period – The 30-day deadline (in some instances, 60-day) to request enrollment in a group health plan following a special enrollment event (i.e., birth, adoption or placement for adoption of a child, marriage, loss of other health coverage, or eligibility for a state premium assistance subsidy).

Benefit Claims and Appeals – The deadline under the plan by which participants may file a claim for benefits (under the terms of the plan) and the deadline for appealing an adverse benefit determination.

Perfecting a Request for External Review – the 4-month period (for the federal external review process; this period could be different for a state external review process) for a claimant to file a request for external review.

Perfecting a Request for External Review – the 4-month period (or 48-hour following receipt of an incomplete request notification, if later) for a claimant to perfect an incomplete request for external review.

COBRA Election Notice – the 14-day deadline (44 days where the employer is the plan administrator) for a plan administrator to provide a COBRA election notice to qualified beneficiaries.

World Observation

This might seem to provide some flexibility to plan administrators. However, it is not likely to be beneficial in the long run for administrators to extend the notice to qualified beneficiaries as most of the other deadlines in COBRA stem from the delivery of this notice.

New Mandates

Employers have been accustomed to more regulatory oversight of their employee benefit plans. There were several new obligations around the Public Disclosure/Transparency rules.

The final Transparency in Coverage rules went into effect, officially, in 2022. There haven't been many reports of enforcement activity and most employers are relying on their vendors to comply with the rules. There is at least some expectation that CMS will step up enforcement once some time has passed and the industry gets a handle on the obligations. It is not known when that will start so employers should be asking their health plan vendors about their compliance with these rules.

The most visible of those rules applies to the requirement of posting machine-readable files on publicly accessible websites. The various insurance carriers and TPAs have taken steps to meet those requirements. Employers should confirm that the information is available without requiring credentials (such as memberships or passwords) for an individual to access those files and post that information on its own public website.

No Surprises Act

The No Surprises Act was incorporated into the Consolidated Appropriations Act, 2021 (CAA) which was passed at the end of 2020. The requirements technically went into effect in 2022. However, as with many of the most recent legislative changes, there was little enforcement activity in the initial effective period.

In general, healthcare plans, including employer-sponsored medical plans,

must pay all claims in a way that protects the plan participant from any balance billing by a provider who is not part of the plan's provider network (unless certain detailed disclosures are provided, and explicit consent is obtained from the plan participant).

Specific services that are affected include:

- Emergency and post-stabilization services (facility and professional fees at hospitals and urgent care centers licensed to provide emergency services)
- Air ambulance services
- Certain non-network services incurred at a network facility (hospital, outpatient department, surgical center) including:
    - Anesthesiology, pathology, radiology, neonatology.
    - Assistant surgeons, hospitalists, intensivists.
    - Diagnostics, radiology, laboratory services.
    - Other services provided by a non-network provider when no network provider is available.

To the extent that there are unpaid bills the provider and the plan must follow a prescribed independent dispute resolution (IDR) process with a final, non-reviewable arbitration process, to resolve any differences. The process includes the plan making an initial payment (qualifying payment amount – QPA) that is based on the median in-network contract rate for the geographic region. Regardless of the outcome of the process, the plan participant will not be responsible for any more than the in-network amount for the service.

Plan sponsors should confirm with their carriers or other vendors that their systems will follow the requirements of the Act and amend plan documents to fully comply with the requirements.

Additional Transparency Requirements

The CAA and the final transparency rules also include some miscellaneous requirements that plan sponsors should confirm are being met by their carriers and other medical plan vendors.

Network Provider Directory

Plans are required to post accurate online directories identifying the network providers and be updated at least every calendar quarter. Moreover, if requested by a plan participant, the plan must provide a directory within one day of the request and retain records of the communication for two years.

To the extent that there is inaccurate information with respect to a provider's network status, the plan must process related claims as in-network claims for purposes of participant cost-sharing.

Continuity of Care

Even if a provider leaves the plan's network, the plan is required to continue to provide coverage to the participant at in-network rates for up to 90 days for:

- Serious and complex conditions.
- Terminal illness.
- Institutional or inpatient care.
- Scheduled non-elective surgery and post-operative care.

ID Cards

ID cards (both physical and electronic forms) provided to participants must now include a significant amount of information not formerly required (and which is difficult to fit on a wallet-sized card). The information required (in addition to the other identifying information normally found on such cards) is:

- Deductibles (both in-network and non-network).
- Out-of-Pocket Maximums (both in-network and non-network).
- Phone number for assistance.
- Website for assistance.

Mental Health Parity – Nonquantitative Treatment Limitations – Comparative Analysis

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) has required employer-sponsored medical plans that cover mental health treatment to provide that coverage no less favorably than it does for medical and surgical benefits. Employers, insurance carriers, and TPAs have struggled with the implementation of those requirements over the years. In particular, one requirement of the regulations is that the plans apply no nonquantitative treatment limitation (NQTL), for example, preauthorization, precertification mandates, medical necessity, facility types, or standards for admission to a network more stringently than it would for a medical/surgical benefit.

As part of the CAA, Congress mandated a new requirement that the plans document their compliance with the obligation to perform a comparative analysis of the various NQTLs and be able to provide that documentation when requested by the DOL. The DOL has been gathering information regarding this requirement and it is anticipated that new enforcement requirements will be published. In the interim, plans should continue to require that their carriers and other vendors are able to comply with any information request from the DOL with respect to the comparative analysis obligation.

Paid Leave Update

Now is a good time to review current paid time off and leave-of-absence policies. As more states and other jurisdictions are requiring employers to provide paid time off to employees, company policies need to reflect not only time off provisions and eligibility requirements, but if/how an employee will be paid for time off (by city, state, employer, or both).

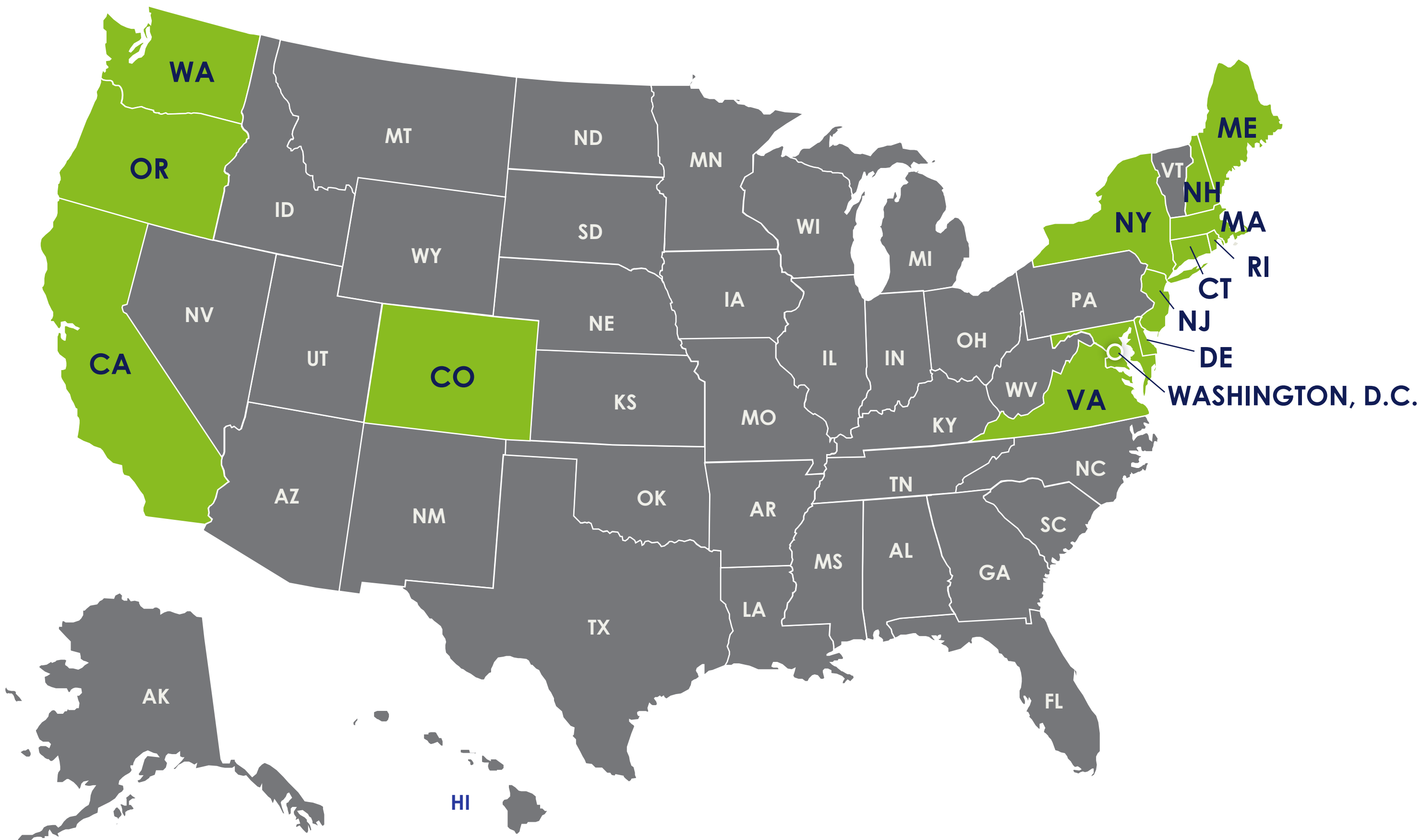
If providing salary continuation to an employee while out on a leave-of-absence, ensure it is coordinated with mandated paid family and leave law, if

applicable, so the employee does not receive more than their normal weekly salary or lose state benefits they have paid into/funded.

In addition to reviewing current policies, now is a good time to review your leave of absence process to ensure templated letters, notices, and forms are updated with required language, including gender-neutral language, and reflect any new company policies and benefits.

The following states (or smaller jurisdictions within those states) have programs in place offering employees paid benefits for certain leave of absence reasons:

CA	CO	DE	MD	NJ	OR	VA
CT	D.C.	MA	NH	NY	RI	WA



Conclusion

Although 2022 is behind us and employers are anxious to return to normal, normal now includes many new mandates and obligations. Employers should make sure to consult with their advisors and all of their vendors to confirm that their vendors are able to comply with the new requirements and will take on that responsibility, in the appropriate circumstances, for the employer.

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About the Author

Jay has more than 30 years of experience as a tax attorney specializing in employee benefits and the application of a broad range of compensation and employer-sponsored benefits programs. His experience combines a high level of technical expertise with creative and practical business-oriented solutions.

This Article is not intended to be exhaustive, nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.