ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, Ken Johnson, Amy Heppner, and Laurie Kirkwood provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley, Carolyn, Ken, Amy, and Laurie are senior members in the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

BREAKING UP IS HARD TO DO: THE END OF THE COVID MANDATES AND OUTBREAK PERIOD EXTENSIONS

On January 30, 2023, the White House announced that both the national emergency and the public health emergency would officially be over as of May 11, 2023. For group health plans, this means an end to several temporary changes that plan sponsors and group health plans were required to make in response to the COVID pandemic, and the beginning of a transition back to pre-pandemic benefits and administration.

Generally, there are two sets of issues that plan sponsors and TPAs need to address in preparation for the transition.

The first issue involves certain benefits, including mandatory benefits like COVID testing and vaccines, and optional benefits like telehealth and EAPs.

The second issue involves the tolling period, known as the "Outbreak Period," for certain deadlines under all ERISA plans (not just group health plans). We look at each in turn, with added practice pointers to assist with planning.

MANDATES AND OTHER RELIEF THAT END AS OF MAY 11, 2023

As of May 11, 2023, group health plans are no longer required to cover certain benefits that were mandated in response to the pandemic. COVID tests, both prescribed and over-the-counter, and out-of-network COVID vaccines no longer have to be covered without cost-sharing after May 11, 2023.

Plan sponsors can continue to cover some or all of these benefits with cost-sharing, prior authorization, or some other medical management requirement.

In the case of OTC COVID tests, if plan sponsors wish to continue coverage, the direct coverage safe harbor no longer needs to be satisfied in order to apply a cost-sharing cap for OTC COVID test purchased at non-preferred providers, and the $12 reimbursement limit can be adjusted.

Also, the 8 tests per person/per month limit can be adjusted for OTC COVID tests from network and non-preferred providers. Note that coverage for in-network COVID vaccines must continue without cost-sharing for non-grandfathered plans under Affordable Care Act (ACA) preventive services requirements.

Also, the IRS will continue to recognize personal protective equipment, or PPE, as a qualified medical expense, so health FSAs and HRAs that allow reimbursement for all qualifying §213(d) medical expenses will continue to reimburse claims for PPE.

Other benefits that were permitted but not required during the emergency periods include stand-alone telehealth for employees who are not eligible for the major medical group health plan of their large employer.

The relief for these stand-alone plans from most ACA mandates continues until the end of any plan year that begins on or before May 11, 2023, unless extended by future legislation or guidance. Other relief includes allowing COVID diagnosing, testing, and vaccines though an EAP while permitting the EAP to maintain status as an "excepted benefit."

Currently, there is no clear guidance on whether EAPs can continue to provide these benefits and still maintain status as an excepted benefit after May 11, 2023. In the absence of further guidance, plan sponsors will need to weigh the risk of noncompliance with continuing to provide this benefit through the EAP until the end of the plan year.

PRACTICE POINTER:

For plan sponsors that wish to end coverage for some or all of these benefits, consider the projected cost to the plan for continuing these benefits through the end of the plan year and whether continuing the benefits would be preferable to making a mid-year change. If continuing coverage until the end of the plan year is preferable, plan sponsors of self-insured plans should discuss this decision with their stop-loss carriers. If making a mid-year change is preferable, plan sponsors need to ensure that notice is properly provided to participants. Additional relief regarding notice of reversal was announced by the agencies (see below). Plan sponsors may also need to amend their plan documents.

RELIEF FOR ADVANCE NOTICE OF COVERAGE REVERSAL

With the emergencies ending May 11, 2023, plan sponsors that choose to cease covering benefits that are no longer mandatory after that date may not have time to provide the advance notice required for material changes.

The agencies provided relief in 2020 and 2021 through FAQs Part 42 and Part 44 that initially allowed plan sponsors to provide notice of added or increased benefits for COVID diagnosis, treatment, or preventive services as soon as administratively feasible rather than 60 days in advance.

FAQs Part 43 states that once the federal emergencies end, plan sponsors (and issuers) that choose to reverse these changes will be considered to have satisfied the advance notice obligation for material modifications if the plan sponsor (or issuer) either (i) previously notified participants of the general duration of the additional benefits

coverage or reduced cost-sharing, or (ii) notified participants within a reasonable time in advance of the reversal of the changes. Note that plan sponsors that choose to continue providing these benefits must comply with applicable requirements to update plan documents or terms of coverage.

PRACTICE POINTER:

Plan sponsors and their TPAs should review all plan communication related to announcements about coverage for COVID diagnosis, treatment, and preventive services to confirm whether the duration of the expanded benefit (i.e., until the end of the emergency) was clearly communicated. If it was not, then then participants need to be notified within a "reasonable time" in advance of the reversal. These plan sponsors will need to evaluate the reasonableness of providing a notice that is less than 60 days in advance of a reversal. Even if adequate notice of the duration was provided in prior notices, a best practice would be to provide a reminder of the upcoming end date.

SPECIAL ISSUES FOR HDHPS AND HSAS

Health Savings Accounts (HSAs) will also encounter transition issues, although these issues are not as closely tied to the expiration of the national emergency or public health emergency.

Generally, pre-deductible coverage can disqualify a person from being eligible to participant in an HSA, but guidance and legislation announced in response to the pandemic provided some relief. IRS Notice 2020-15 allows HDHPs to cover COVID testing before the deductible without disqualifying HSA eligibility, and this remains in effect until the IRS modifies or updates this guidance, regardless of the date that the emergency periods end.

Also, the Coronavirus Aid, Relief, and Economic Security (CARES) Act permitted HDHPs to cover pre-deductible telehealth and other remote services offered through the HDHP without disqualifying a person from HSA participation.

This original relief expired December 31, 2022, regardless of plan year. Although the relief was most recently extended in December 2022 by the Consolidated Appropriations Act, 2023, this extension applies only to **plan years** starting on or after January 1, 2023 and before January 1, 2025.

Relief for non-calendar year plans expired on December 31, 2022, and no relief is available in 2023 for non-calendar year plans until the beginning of the 2023 plan year. For example, this relief for a plan year that began on July 1, 2022 expired on December 1, 2022, and will not apply to this plan until its 2023 plan year begins on July 1, 2023.

SPECIAL ISSUES FOR MHPAEA QTLS

In light of the mandates on group health plans to cover COVID diagnostic testing, the agencies announced enforcement relief for the quantitative treatment limitation requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA).

For purposes of compliance with the "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations, no enforcement action will be taken against any plan or insurer that disregards benefits for the items and services that are covered without cost-sharing as required by the Families First Coronavirus Response Act (FFCRA).

The relief was intended to be temporary and applies to the COVID diagnostic testing mandated by FFCRA, which is tied to the public health emergency.

Presumably this non-enforcement protection also ends on May 11, 2023, and while (depending on QTL testing results) plan changes may not be required in all cases, any non-mandated COVID coverage must be taken into account for QTL testing.

OUTBREAK PERIOD TRANSITION OF TOLLING PERIODS

During the national emergency, certain deadlines for ERISA plans were extended by disregarding the "Outbreak Period."

The Outbreak Period began on March 1, 2020 and will end 60 days after the end of the national emergency. For purposes of determining certain periods and dates related to events that occur during the Outbreak Period, ERISA plans must disregard a portion of the Outbreak Period that is the lesser of (i) one year after the otherwise applicable triggering event date (the "one-year rule") or (ii) 60 days after the end of the national emergency (i.e., May 11, 2023), which is July 10, 2023.

The following periods and dates are affected by the Outbreak Period extensions:

- Furnishing COBRA election notice
- COBRA election period
- COBRA premium payment (initial payments and monthly payments)
- COBRA notice period for second qualifying events and determinations of disability
- Claims and appeals (for all ERISA plans), including for health FSAs and HRAs (note that dependent care FSAs and HSAs are not ERISA plans)
- External review requests and filing a perfection of a request
- HIPAA special enrollment request

Prior to the announcement of the end of the national emergency, the one-year rule was the only rule that plan sponsors and TPAs needed to apply. Now that the end of the national emergency is fixed at May 11, 2023, the portion of the Outbreak Period that is to be disregarded will be cut off at July 10, 2023.

Example: Mary is a participant in a group health plan. On March 1, 2023, Mary received medical treatment for a condition covered under the plan, but a claim relating to the medical treatment was not submitted until April 1, 2024. Under the plan, claims must be submitted within 365 days of the participant's receipt of the medical treatment. Was Mary's claim timely?

Conclusion: Yes. For purposes of determining the 365-day period applicable to Mary's claim, the Outbreak Period is disregarded. Under these facts, the disregarded period is March 1, 2023 through July 10, 2023. Therefore, Mary's last day to submit a claim is 365 days after July 10, 2023, which is July 10, 2024, so Mary's claim was timely.

A general rule of thumb here is that events occurring on or before July 10, 2022 will be subject to the one-year rule, while events that occur on or after July 11, 2022 and before July 11, 2023 will generally use July 11, 2023 as "day 1" for purposes of determining an applicable time period.

For plan sponsors that did not provide the COBRA election notice to qualified beneficiaries within the usual, non-Outbreak Period timeframe, calculating deadlines for COBRA elections will be more complicated.

Also, there is some uncertainty regarding the special COBRA premium rule involving COBRA elections that are made outside the initial 60-day election period but within the Outbreak Period extension, as well as the deadline for COBRA monthly premiums.

Less
is more.

We need only one word to describe how our culture of innovation leads us to handle the complexities of healthcare. Through a single platform, we deliver transformative models of care that de-clutter the member health journey while maximizing savings for the plan sponsor.

Driven by data, we provide clarity into the right decisions to simplify the complex. That's why our customers choose Valenz and why they stay with us. It's our culture that makes us different, which is why we wear it on our sleeves.

See how Valenz delivers smarter, better, faster healthcare by keeping it simple in a complex world: visit **valenzhealth.com** or call **(866) 762-4455**.

Valenz® HEALTH

SIIA Proud to be a Diamond Member

PRACTICE POINTER:

As a best practice, plan sponsors and TPAs should prepare reminder communications to explain deadlines to prevent participants and enrollees from missing crucial deadlines. This includes reminders about the tolling of the Outbreak Period for qualified beneficiaries, including those who have not yet elected COBRA but who will still have an opportunity to elect COBRA after July 10, 2023 as a result of the Outbreak Period extension.

ACTION ITEMS

Plan sponsors and TPAs should begin planning for transition by:

- Determining whether to continue providing benefits that are no longer mandatory after May 11, 2023
- Review COVID communications to determine whether duration of increased benefit was clearly stated
- Prepare reminders for end dates of certain benefits (if applicable)
- Communicate upcoming deadlines related to the end of the Outbreak Period to participants/enrollees
- Update SPDs and amend plan documents (if applicable) ■