THE SELF-INSURED HEALTH PLAN COMPLIANCE CLOCK COUNTS DOWN FOR 2023

Written By David Ostrowsky

For HR professionals, the fourth quarter invariably presents considerable challenges. In addition to handling daily operational work involving employee benefits, HR departments are bracing for the deadline-driven annual open enrollment process—while navigating the upcoming holiday season, no less. With all the looming federal and state deadlines and corresponding action items, it can be overwhelming, if not daunting, when it comes time to review self-funded health plan documents, whether they be summary plan descriptions (SPDs), plan documents (PDs), combined SPD/PDs, wrap documents, cafeteria documents, and SBCs.

The following guide outlines several critical compliance deadlines and reminders germane to end-of-year planning, though it should be noted that this is not meant to be a complete and exhaustive list of compliance requirements deadlines.

DECEMBER 31 – SUBMIT TO CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) THE GAG CLAUSE PROHIBITION ATTESTATION (GCPCA).

Under the Consolidated Appropriations Act of 2021 (CAA), group health plans and health insurance issuers are required to annually submit an attestation that they are in compliance with the gag clause prohibition, a rule that bars plans and issuers from entering into agreements with providers, TPAs, or other service providers who would inhibit either provider-specific cost or quality information sharing with plan members or claims data sharing with plan sponsors as well as their service providers.

The first gag clause prohibition attestation is due on December 31, 2023, covering the period starting December 27, 2020, or the effective date of the group health plan coverage (if later), through the attestation date. Subsequent attestations, spanning the period since the last preceding attestation, are due by December 31 of each subsequent year.

The primary burden of responsibility associated with the GCPCA submission falls on issuers and TPAs. As such, it is advisable for plans and issuers to read their service agreements to determine how the GCPCA is covered and to ensure that everything is in line for a submission to be executed by December 31.

DECEMBER 31 – DISTRIBUTE ANNUAL WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE.

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that gives protection to patients who opt to have breast reconstruction in connection with a mastectomy. By December 31, both ERISA and non-ERISA calendar year plans are required to distribute the annual WHCRA notice to their respective participants (employees and retirees), COBRA enrollees, and other beneficiaries receiving benefits and alternate recipients under QMCSOs. Of note, self-insured state and local government health plans have the ability to opt-out. Generally speaking, the WHCRA notice is disseminated during initial enrollment and then annually, before each plan year. Electronic disclosure is allowed in accordance with the Department of Labor (DOL) guidelines.

It should be mentioned that WHCRA mandates group health plans and health insurance companies (including HMOs) to notify participants about coverage required under the law. Notice regarding the availability of these mastectomy-related benefits must be given:

1. To participants and beneficiaries of a group health plan during enrollment, and to policyholders when an individual health insurance policy is issued; and
2. On a yearly basis to group health plan participants and beneficiaries, and to policyholders of individual policies.

However, WHCRA does not require group health plans or health insurance issuers to cover mastectomies. If a group health plan or health insurance issuer decides to cover mastectomies, then the plan or issuer is likely subject to WHCRA requirements.

DECEMBER 31 – DISTRIBUTE NOTICE OF PREMIUM ASSISTANCE UNDER MEDICAID OR THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP).

By December 31, both ERISA and non-ERISA calendar year plans must distribute the notice of premium assistance under Medicaid or the Children's Health Insurance Program (CHIP) to all employees, irrespective of their

eligibility or enrollment status, traditionally as a separate document – even if provided in conjunction with enrollment materials. This notice should be provided by the last day of the plan year prior to the year to which the notice relates.

FIRST DAY OF OPEN ENROLLMENT – DISTRIBUTE THE SUMMARY OF BENEFITS AND COVERAGE (SBC).

For benefit-eligible employees who have to make affirmative benefit elections, the SBC, essentially an overview of a health plan's costs, benefits, covered healthcare services, and other features that are critical to healthcare consumers, needs to be provided at the onset of open enrollment. For those employees who do not have to make affirmative benefit elections, the SBC needs to be provided 30 days before the beginning of the plan year. This rule applies to both ERISA and non-ERISA plans.

FIRST DAY OF OPEN ENROLLMENT - MICHELLE'S LAW NOTICE.

"Michelle's Law" is a piece of federal legislation that extends eligibility for group health benefit plan coverage to a dependent child enrolled in a higher education institution at the start of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension safeguards eligibility of a sick or injured dependent child for up to one year. Michelle's Law Notice has to be provided during open enrollment if the plan covers full-time students beyond age 26. This rule also applies to ERISA and non-ERISA plans. ■

As a Content Specialist for The Phia Group, David Ostrowsky manages many of the company's internal and external communication functions. He is also a regular contributor to the company's blog as well as to various healthcare periodicals, such as The Self-Insurer.

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