GBS Annual Conference

Health Benefits Compliance
Key Updates for 2023

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What We'll Be Covering Today

- END OF COVID EMERGENCY DECLARATIONS
- TRANSPARENCY UPDATES
- AFFORDABLE CARE ACT UPDATES
- CONSOLIDATED APPROPRIATIONS ACT (CAA) OF 2023

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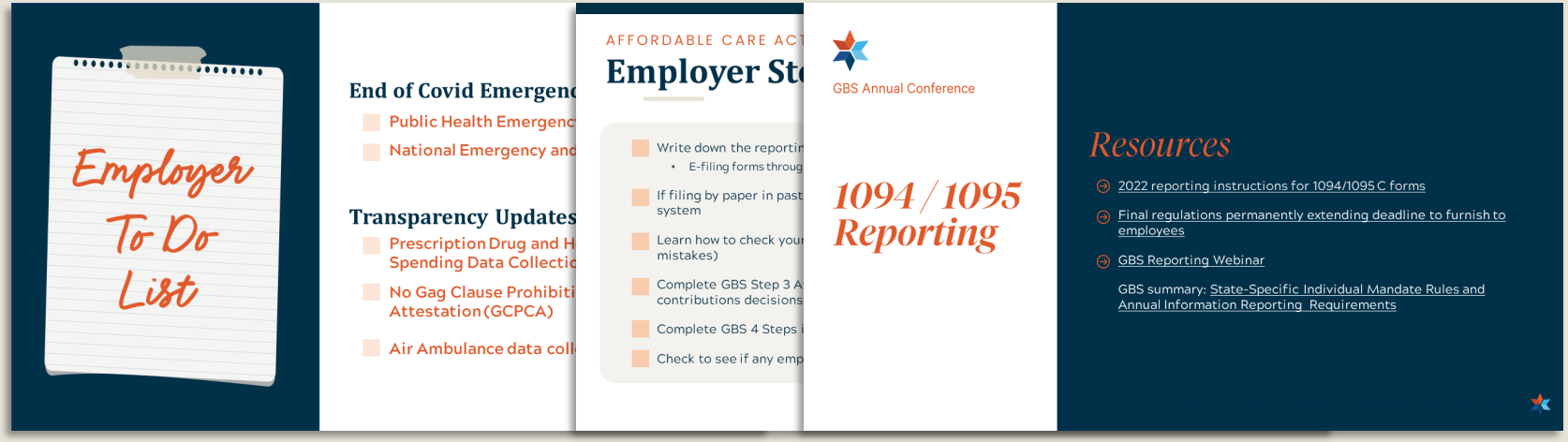
Session Objective

Today's deck contains recent updates that will help you keep your group health plan in compliance. Each topic is presented with background information, an update, a checklist of employer steps, and links to additional resources.

Not all topics in this deck will be covered in today's session, and some will get only a light touch, so be sure to download and save the deck as a resource.



VIEW & DOWNLOAD THE FULL PRESENTATION

End of COVID Emergency Declarations

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End of COVID Emergency Declarations

- Background
- Timeline
- Public Health Emergency
- National Emergency and Outbreak Period

END OF COVID EMERGENCY DECLARATIONS

Background

The COVID-19 pandemic created a need for new temporary rules and/or adjustments to current rules

- There were several emergency declarations, each with a different purpose, date and requirements, but two declarations impact group health plans

Emergency Declarations that Directly Impact Group Health Plans

Public Health Emergency *Effective January 2020* *Declared by HHS*	Required group health plans to cover COVID related health services like vaccines and tests
National Emergency *Effective March 2020* *Declared by President*	Didn't directly impact group health plans - but the "Outbreak Period" that runs parallel to the National Emergency did impact group health plans The "Outbreak Period" extended certain deadlines under HIPAA, COBRA and CLAIMS/APPEALS rules. During this period, these deadlines were extended and did not terminate until the earlier of: 1) one year, or 2) the end of the "Outbreak Period" The "Outbreak Period" continues until 60 days after the National Emergency ends UNLESS the 60 days is extended by the DOL

END OF COVID EMERGENCY DECLARATIONS

Timeline

Expiration Timeline - a Moving Target

- **2020 through 2022** both the National Emergency and the Public Health Emergency were extended several times. March 2023 (National Emergency) and April 2023 (Public Health Emergency) were the upcoming expiration dates unless they were extended again
- **January 2023** the President extended both emergencies until May 11, 2023 so both emergencies would end on the same date
  - Because the "Outbreak Period" associated with the National Emergency ends 60 days after the National Emergency ends, the Outbreak Period would end on July 10, 2023
- **March 2023** Congress passed a Joint Resolution that, if signed by the President, would end the National Emergency immediately (sooner than May 11, 2023)
- **April 10, 2023** the President signed the Joint Resolution to immediately end the National Emergency
  - The "Outbreak Period" however, will not end June 9, 2023 as expected (60 days after end of NE)
  - Instead, the end of the "Outbreak Period" will still be on July 10, 2023 to avoid potential confusion and changes to administrative processes already in progress.
- **May 11, 2023** is still the scheduled Public Health Emergency end date

END OF COVID EMERGENCY DECLARATIONS

Timeline Summary

Emergency	Expiration Date	Impact
Public Health Emergency (PHE)	May 11, 2023	Certain COVID coverage no longer mandatory
National Emergency (NE)	~~May 11, 2023~~ April 10, 2023	Triggers 60-day countdown to end of “Outbreak Period” *60-day countdown extended to from June 9 to July 10*
NE “Outbreak Period”	~~June 9, 2023~~ July 10, 2023	Certain HIPAA, COBRA & claims / appeals deadlines that had been extended beyond normal deadlines terminate

END OF COVID EMERGENCY DECLARATIONS

Public Health Emergency

	Requirements for Group Health Plans	Options for Group Health Plan
During Public Health Emergency	Must cover COVID-19 vaccines/boosters w/o cost sharing and without pre-auth for both in-network and out-of-network providers Must cover COVID diagnostic testing and testing related services w/o cost sharing and pre-auth Must cover up to 8 over-the-counter (OTC) home tests per month without doctor order or prescription • Effective as of January 15, 2022 • Home testing kits must be approved by the FDA • Can limit reimbursement cost to $12.00	May offer stand-alone telehealth benefits to individuals who are not eligible for major medical coverage
After Public Health Emergency	Must continue to cover COVID-19 vaccines at no cost with **in-network** providers	May continue to cover COVID-19 vaccines at no cost with o**ut-of-network providers** May continue stand-alone telehealth benefits through end of current plan year if currently offering. No need to make mid-year change, but cannot offer at new plan year

END OF COVID EMERGENCY DECLARATIONS

National Emergency and Outbreak Period

"Outbreak Period" Requirements During the National Emergency

- **Extend HIPAA Special Enrollment Deadlines**
  - The 30-day period (or 60-day period, if applicable) to request HIPAA special enrollment.
- **Extend COBRA Deadlines**
  - The 60-day election period for COBRA continuation coverage.
  - The date for making COBRA premium payments.
  - The date for individuals to notify the plan of a COBRA qualifying event or new disability
  - The date for plan sponsors and administrators to provide a COBRA election notice
- **Extend Claims and Appeals Deadlines**
  - The date within which individuals may file a benefit claim under a plan's claims procedures.
  - The deadlines for requesting internal and external appeals for adverse benefits determinations.

"Outbreak Period" Requirements After the National Emergency

- **Deadlines go back to normal timeframes**

END OF COVID EMERGENCY DECLARATIONS

Employer Steps

Public Health Emergency (for Self funded)

- Confirm COVID related health coverage requirements are still in place
- Decide whether to continue COVID related optional health coverage
- Check to ensure any COVID related coverage has parity with the Mental Health Parity and Addiction Equity Act (MHPAEA)

National Emergency and "Outbreak Period"

- Make list of individuals impacted by the end of "Outbreak Period"
- Consider extending some/all deadlines for an additional 30 days to address/avoid confusion by impacted individuals
- Send advance notices to impacted individuals to alert them of new deadlines

Public Health Emergency & National Emergency and "Outbreak Period"

- Review ERISA plan and notice rules and ensure all plan documents and participant communications accurately reflect coverage, exclusions, and limitations with any changes to coverage or deadlines

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End of COVID Emergency Declarations

Resources

General Resources

- DOL FAQs Issued March 29, 2023
- DOL Blog Post "What Does the End of the COVID-19 Public Health Emergency Mean for my Health Benefits?"
- HHS Fact Sheet PHE Transition Roadmap

Participant Facing

- DOL Blog Post "Five Important Changes to Your Health Coverage Once the COVID-19 Public Health Emergency Ends"

Congressional Actions

- Congress.gov H.R. 382 - Pandemic is Over Act
- Congress.gov H.J.Res.7 - Relating to a national emergency declared by the President on March 13, 2020.

Transparency

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Transparency

- **Background**
- **Timeline Summary**
  - **2020-2022**
  - **2023**
    - Prescription Drug and Health Care Spending Data Collection (RxDC)
    - No Gag Clause Prohibition Compliance Attestation (GCPCA)
    - Air Ambulance data collection (AADC)
  - **2024 and Beyond**

TRANSPARENCY

Background

What

- **“Transparency” is a reference to a large collection of separate rules, regulations and statutory provisions intended to create more transparency within the health care industry and thereby improve costs and protect consumers**

Impact

- **Due to the significant amount of new rules, there are additional obligations and reporting requirements for:**
  - Health insurers/carriers
  - Health care providers
  - Group health plans (and employers that sponsor them)

Timeline

- **Similar to ACA, the effective dates for various rules/provisions vary to allow for a gradual ramp up**

Background

Overview of Transparency Rules

Transparency in Coverage Federal Rules (TiCFR)

Consilidated Appropriations Act (CAA 2021)

- Transparency
- No Surprises Act
- MHPAEA Reporting

Summary Timeline

Transparency Rules 2020 & 2021 Deadlines

Date	Rule	What
December 27, 2020	CAA Transparency Rules	No Gag Clauses (on pricing related issues) are allowed in contracts between insurers and/or group health plans and: TPAs, providers, provider networks, and more
February 10, 2021	CAA Mental Health Parity Reporting Rules	Departments could begin requesting MHPAEA reports from Group Health Plans (and the employers that sponsor those plans). The reports contain information about the plan's compliance with parity.
December 27, 2021	CAA Transparency Rules	After this date, **new** Group Health Plan contracts must include Section 408(b)(2)(B) ERISA compensation disclosure

TRANSPARENCY

Summary Timeline

Transparency Rules 2022 Deadlines

Date	Rule	What
Plans beginning on or after January 1, 2022	CAA No Surprises Act	Ban on balance billing (including providing claims and balance billing disclosures and posting on website and EOB statements federal/state surprise bill protections), right to continuity of care for at least 90 days (when in-network providers change), transparency in identification (ID) cards, and accurate and up to date provider directory information
~~**January 1, 2022**~~ **July 1, 2022**	TiCFR	Disclose on a public website pricing information: (File 1) negotiated rates for covered items and services offered in-network, and (File 2) historical payments to, and billed charges from, out-of-network providers
~~**December 27, 2022**~~ **January 31, 2023**	CAA Transparency Rules	Report information (RxDC reports) about prescription drugs and health care spending to the Departments. These reports covered data from 2020 and 2021 calendar years . Thereafter, RxDC reports are due are due by June 1 each year

Summary Timeline

Transparency Rules 2023 Deadlines

Date	Rule	What
Plans beginning on or after January 1, 2023	TiCFR	Disclose to participants enrolled in the plan a list of 500 shoppable items and services via an internet-based self-service tool. This allows participants to shop, compare and better understand health care costs before receiving care.
		Must provide price cost-sharing comparison tool for participants by phone and website
Plans beginning on or after January 1, 2023	CAA No Surprises Act	Because this provision very similar to the above TiCFR rule, compliance with the TiCFR tool should satisfy the CAA's requirements. Except this rule requires plans to provide cost comparison information *over the telephone upon request*, which is an additional requirement not required under the TiCFR

Summary Timeline

Transparency Rules 2023 Deadlines

Date	Rule	What
January 31, 2023	CAA Transparency Rules	Deadline for **Pharmacy Benefits and Drug Costs (RxDC) reports** covering data from 2020 and 2021 calendar years (originally due December 27, 2022, but extended)
June 1, 2023	CAA Transparency Rules	Deadline for **Pharmacy Benefits and Drug Costs (RxDC) reports** covering data from 2022 calendar year. Due every year thereafter by this date.
December 31, 2023	CAA Transparency Rules	First due date for **Gag Clause Prohibition Compliance Attestation** that no Gag Clauses exist in any contracts between group health plans and service providers

TRANSPARENCY IN 2023

Prescription Drug Reporting (RxDC)

TRANSPARENCY

Prescription Drug and Health Care Spending Data Collection (RxDC)

Background

- **The CAA Transparency rule requires insurers/TPAs and employers (that sponsor group health plans) to submit information about certain prescription drug and health care spending.**
  - The information is submitted online through the HIOS system

Why

- **The collected data is used by federal regulators to:**
  - Identify major drivers of increases in prescription drug and health care spending
  - Understand how prescription drug rebates impact premiums and out-of-pocket costs
  - Promote transparency in prescription drug pricing
- **Findings from Reports**
  - The Departments will publish findings about prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs and also provide to Congress

TRANSPARENCY

Prescription Drug and Health Care Spending Data Collection (RxDC)

When

- **Reports are due June 1 of each year**
- **The report is filed with the Department of Health and Human Services (HHS), via the CMS portal**
  - Exception: the first reports (2020/2021) were due December 27, 2021 (moved to January 31, 2023)
  - 2022 data reports are due by June 1, 2023
  - 2023 data reports are due by June 1, 2024
  - 2024 data reports are due by June 1, 2025

The Contents of the RxDC report

- **One P2 file**
- **Eight D files (D1, D2, D3, D4, D5, D6, D7, D8)**
- **Narrative file**

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Prescription Drug and Health Care Spending Data Collection (RxDC)

More Detail on the Contents of the RxDC report

- **One P2 file**
  - This is like a cover sheet with basic information about the plan, like the plan year beginning and end dates, the number of members, and the states in which the plan or coverage is offered.
- **Eight D files**
  - D1 Premium cost and life-years
  - D2 Spending and cost-sharing by category
  - D3 Top 50 Most Frequent Brand Drugs
  - D4 Top 50 Most Costly Drugs
  - D5 Top 50 Drugs by Spending Increase
  - D6 Rx Totals
  - D7 Rx Rebates by Therapeutic Class
  - D8 Rx Rebates for the Top 25 Drugs
- **Narrative file**
  - Eight questions/topics are answered in narrative form

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Prescription Drug and Health Care Spending Data Collection (RxDC)

Updates for 2022 RxDC reports

- **Instructions issued in March 2023 for 2022 reports include a few clarifications and changes**
  - Multiple vendors are allowed to submit the same data file for a plan and are not required to coordinate to submit a single data file
    - This means a TPA, telehealth provider, pharmacy benefit manager (PBM) etc. may all submit files separately to HIOS system without coordinating with other vendors
    - Although coordinating with other vendors to submit one data file for a plan is encouraged, separate service providers could decide not to coordinate with other vendors
    - For 2022 reports, generally, we are generally seeing TPAs and carriers continuing to coordinate with vendors
  - No *General Good Faith Efforts r*elief that existed for 2020 and 2021 reports
  - No *Nonenforcement r*elief for reporting average monthly premium paid by employers v. members
  - Self-funded plans cannot use the COBRA rate to determine total plan cost
    - Must calculate/report the total annual cost actually paid

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Prescription Drug and Health Care Spending Data Collection (RxDC)

Employers that sponsor INSURED plans

- **Insurers are typically submitting the RxDC reports for plans. This is because the carrier already has most the information required for fully insured plans with integrated Rx**
- **The carriers have already reached out to groups for the June 2023 deadline**
- **Carriers asked groups to complete some simple tasks**
  - Groups received an email requesting information, likely limited to information needed for just the P2 file and one question to help with the D1 file
    - The P2 file contains basic employer information,
    - The D1 file includes a request for premium cost, meaning simply the average premium paid by members and the average premium paid for by employers. This is information the insurer does not have

CONSOLIDATED APPROPRIATIONS ACT OF 2023

Employer Steps – *Insured Plans*

Don't get overwhelmed!
The information requested is typically very simple to gather and provide

- Respond promptly to any communication from your insurer about RxDC reporting,
  - Do not miss their internal deadlines
  - If deadlines are missed, the carrier may submit the report without your information which means you'll have to submit on your own, through the HIOS system, which can be tricky to navigate
- Consider verifying (or updating) contracts with carrier and responsibility to satisfy the RxDC requirements, and if possible, add indemnification provisions
- Reach out to your GBS Broker team if you have any questions. - they are aware of this process.

TRANSPARENCY

Prescription Drug and Health Care Spending Data Collection (RxDC)

Employers that sponsor Self / Level funded plans

- **TPAs are typically collecting information from all relevant sources and submitting the RxDC reports on behalf of group health plans.**
- **TPAs have already reached out to groups for the June 2023 deadline**
- **TPAs asked groups to complete some tasks in a few more substantial ways**
  - Groups received an email requesting information requesting information for the P2 file and information for most of the D1 file
    - The P2 file contains basic employer information
    - D1 file includes a request for premium cost (the average premium paid by members and the average premium paid for by employers). This is information the TPA does not have.
    - The TPA may also ask for additional information requested in the rules for the D1 file

Employer Steps – Self / Level Funded Plans

- Respond promptly to any communication from your TPA about RxDC reporting
  - Do not miss your TPA's internal deadlines
  - Your TPA may be willing to submit the files containing information/data you have, but if you miss deadlines, they will likely report without it. That means you will need to gather information AND submit on your own through HIOS system
- Clarify whether your TPA is submitting the report on your behalf
  - If you receive a communication from the TPA to create a HIOS account, this means the TPA will not be submitting the P2 and D1 files on your behalf
  - If so, plan in advance, get your HIOS account and learn how to submit within HIOS
- Consider verifying (or updating) contracts with TPA and include TPA responsibility to satisfy the RxDC requirements, and if possible, add indemnification provisions
  - Follow up, remember that even with a written agreement, it is not possible to shift the legal responsibility from the group health plan to your TPA
- Reach out to your GBS Broker team if you have any questions - they are aware of this process.

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Prescription Drug and Health Care Spending Data Collection (RxDC)

Resources

General Resources

- CMS RxDC - Main Page and Resource Center
- CMS FAQs (starting at pg. 10) ACA and CAA, 2021 Implementation Part 49
- DOL FAQs ACA and CAA, 2021 Implementation Part 56
- RxDC FAQ Matrix
- DOL Enforcement FAQ on 2020 / 2021 Submissions
- CAA of 2021

HIOS Resources

- CMS RxDC Training Webinar (March 2023)
- HIOS RxDC User Manual
- CMS Portal

TRANSPARENCY IN 2023

No Gag Clause in Contracts - Attestations

TRANSPARENCY

No Gag Clause Prohibition Compliance Attestation (GCPCA)

Background

- **Insurers/carriers and employers that sponsor group health plans must not agree to Gag Clauses in contracts with vendors and providers, and must annually submit an attestation confirming same**

Definitions

- **Generally**
  - A gag clause is a clause in a contract that directly/indirectly restricts the parties from sharing certain data or information
- **Within the health benefits context**
  - A gag clause would restrict an issuer (insurance carrier) or a group health plan (an employer that sponsors that plan) from sharing specific data and information to another party.
  - Entities that (in past) may include gag clauses in contracts with a carrier or group health plan
    - a health care provider
    - a network or association of providers
    - a TPA
    - another service provider offering access to a network of providers

TRANSPARENCY

No Gag Clause Prohibition Compliance Attestation (GCPCA)

Example of Gag Clause

- A contract between a TPA and a group health plan that states the plan sponsor's (employer's) access to provider-specific cost and quality-of-care information is *only at the discretion of the TPA*

The Details: Contracts May NOT restrict an issuer or group health plan from:

- Providing provider-specific cost or quality-of-care information or data to referring providers, the plan sponsor, participants, beneficiaries or enrollees (or individuals eligible to become participants, beneficiaries or enrollees of the plan or coverage);
- Electronically accessing de-identified claims and encounter information or data for each participant, beneficiary or enrollee upon request and consistent with privacy rules under the Health Insurance Portability and Accountability Act (HIPAA), the Genetic Information Nondiscrimination Act (GINA), and the Americans with Disabilities Act (ADA); and
- Sharing information or data described in (1) and (2) above or directing such information to be shared with a business associate, consistent with applicable privacy rules.

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No Gag Clause Prohibition Compliance Attestation (GCPCA)

When/How

- **Insurers and employers that sponsor group health plans must submit GCPC attestations each year**
  - Submitted through the CMS website no later than December 31 each year
  - First attestation is due by December 31, 2023

Attestations Do Not Apply to

- Plans or issuers offering only excepted benefits
- Issuers offering only short-term, limited-duration insurance
- Medicare and Medicaid plans
- State Children's Health Insurance Program (CHIP) plans
- TRICARE program
- Indian Health Service program
- Plans under "Basic Health Program"
- HRAs and other account-based plans

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Employer Steps

- Review contracts to ensure they do not contain gag clauses.
  - Some explicit, direct violations will not be difficult to identify, but provisions that have the effect of restricting the disclosure of information or data may not be as obvious.
  - For example, watch for provisions that would restrict provider-specific cost or quality information sharing with plan members or claims data sharing or individual claims pricing
- Prepare in advance to provide the compliance attestation by December 31, 2023.
- **Fully insured:** Confirm the insurer is submitting for the plan and follow up to confirm when completed
  - If the issuer/carrier provides the attestation, the plan does not also need to provide an additional attestation
- **Self/level funded:** Contact the TPA to determine whether they will provide the attestation for the plan
  - If so, consider updating contract to confirm TPA responsibility in writing. Understand even with written agreement, the legal responsibility remains with the plan sponsor (employer)
  - If not, watch for updates from GBS on submission rules so you can learn and submit on time

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No Gag Clause Prohibition Compliance Attestation (GCPCA)

Resources

- CMS issue FAQ in February 2023
- Attestation website
- Instructions, Excel template, and more information at CMS
- CAA of 2021

Complaints

Interested parties with concerns about a plan's or issuer's compliance with the gag clause prohibition may:

- contact the No Surprises Help Desk at 1-800-985-3059
- submit a complaint online
- contact the applicable state authority

For ERISA plans, individuals may contact DOL for help at www.askebsa.dol.gov or 1-866-444-3272.

Summary Timeline

Transparency Rules 2024 & 2025 Deadlines

Date	Rule	What
January 1, 2024	TiCFR	Disclose to participants, through an internet based self-service tool, the remaining items and services that were not included in the first 500 shoppable items and services. Like the first 500 items, this allows participants to shop, compare and better understand health care costs before receiving care.
March 31, 2025 *(estimated date)*	CAA No Surprises Act	Provide Air Ambulance Data Collection (AADC) reports containing information about air ambulance services that were provided during each calendar year. This was originally due by March 31, 2023, but now extended with no set date yet.

TRANSPARENCY IN 2023

Air Ambulance Data Collection (AADC)

TRANSPARENCY

Air Ambulance Data Collection (AADC)

Rule

- The No Surprises Act (NSA) requires air ambulance providers, insurance companies, and employers (that sponsor group health plans) to submit certain information about air ambulance services that were provided during a calendar year.

Intent

- The gathered data will be used to develop a comprehensive public report on air ambulance services with intent to improve processes, transparency and consumer protections

Applies to:

- Both fully insured and self/level funded group health plans and insurers
- Exceptions:
  - Excepted benefits
  - Health reimbursement arrangements (HRAs)
  - Short-term, limited-duration insurance

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Air Ambulance Data Collection (AADC)

When

- **Originally, first reporting deadline was March 31, 2023**
- **Currently, estimated first report deadline will be March 31, 2025**
  - Deadlines were based on the expectation that final regulations would be issued before the end of calendar year 2021, but final regulations were not issued in 2021 nor 2022.
  - Reports will not be due until after the final rules are published, but rules expected sometime in 2023

Details: Information/Data to be Reported

- **Required data for each air ambulance claim would include:**
  - Certain transport information, such as the aircraft type, loaded miles, pick-up and drop-off locations
  - Whether the transport was emergency
  - Whether the transport was an inter-facility transport
  - Certain claim adjudication information (including whether the claim was paid, denied, or appealed; denial reason; and appeal outcome)
  - Certain claim payment information (including submitted charges, amounts paid by each payor, and cost-sharing amount)

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Employer Steps

No Steps for Now - waiting for final rules

Fully insured
A plan sponsor (employer) likely will be able to allow the insurer to provide the report to satisfy the requirements

Self/level funded
A plan sponsor (employer) will likely be able to contract with a TPA to submit the report for the plan, but the employer would remain responsible for any reporting failures.

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Air Ambulance Data Collection (AADC)

Resources

- CMS page with more information and links
- Federal Register: Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement
- CAA of 2021

More resources will be available after final regulations are issued

Summary Timeline

Transparency Rules
Delayed or Deferred Deadlines

Date	Rule	What
Delayed Effective Date until Guidance is Issued	CAA No Surprises Act	Advanced Explanation of Benefits and Good Faith Estimates (originally due by January 1, 2022)
Deferred Enforcement	TiCFR	Public Disclosure - File 3 (file for prescription and drug data) will be reconsidered in future rulemaking. Because this rule is so similar to the CAA RxDC reporting requirements, it is possible this rule will be deferred indefinitely to avoid duplication

Key Updates: Affordable Care Act

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Health Benefits Compliance 2023

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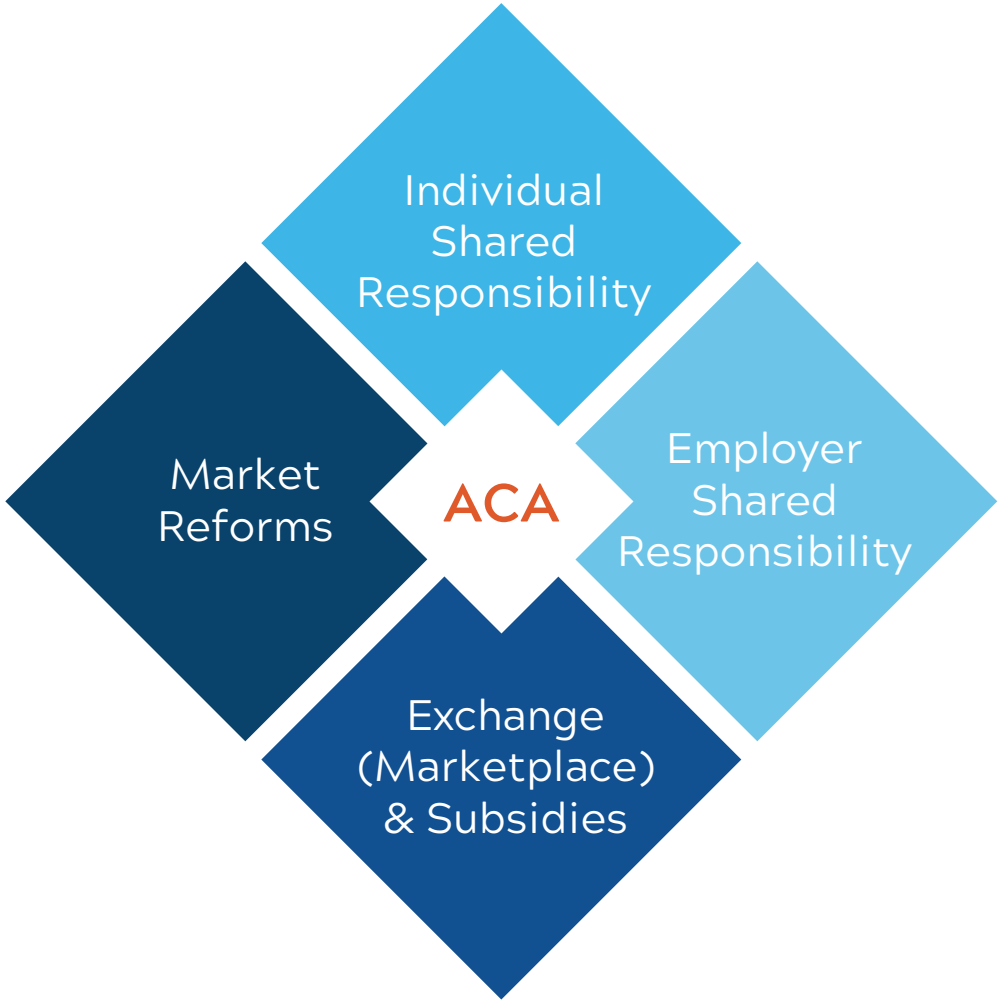
Key Updates: Affordable Care Act

- **Background**
- **1094/1095 reporting**
  - Mandatory electronic filing
  - Reminders
    - Reminder deadline to furnish extended
    - Reminder on form mistakes
    - Reminder on Affordability safe harbor
    - Reminder on state reporting
- **Section 1557 non-discrimination**
- **Preventive Services**

AFFORDABLE CARE ACT

Background

- **In March 2010, two large, comprehensive health care reform laws were enacted**
- **The laws are typically referred to as:**
  - Health Care Reform (HCR)
  - Obamacare
  - Affordable Care Act (ACA)
- **Effective Dates**
  - The rules began taking effect in 2010 and ramped up over several years, with most provisions effective by 2016



AFFORDABLE CARE ACT

Background

Intent

- **Many ACA provisions intended to:**
  - Extend coverage to uninsured individuals/families
  - Lower costs for insured individuals/families
  - Improve overall efficiency and effectiveness within health care system

Strategies

- **Strategies included:**
  - Expanding Medicaid to more low-income individuals/families
  - Offering subsidies (financial assistance) in the Exchange/Marketplace for individual/families living above Medicaid eligibility but living below 400% of Federal Poverty Level
  - Implementing procedures for “large employer” offers of group health coverage to full-time employees.
  - Supporting innovative methods designed to lower costs and improve systems
  - Eliminating (then standard) industry practices including: 1) insurance rescission, and 2) denial of coverage due to pre-existing conditions

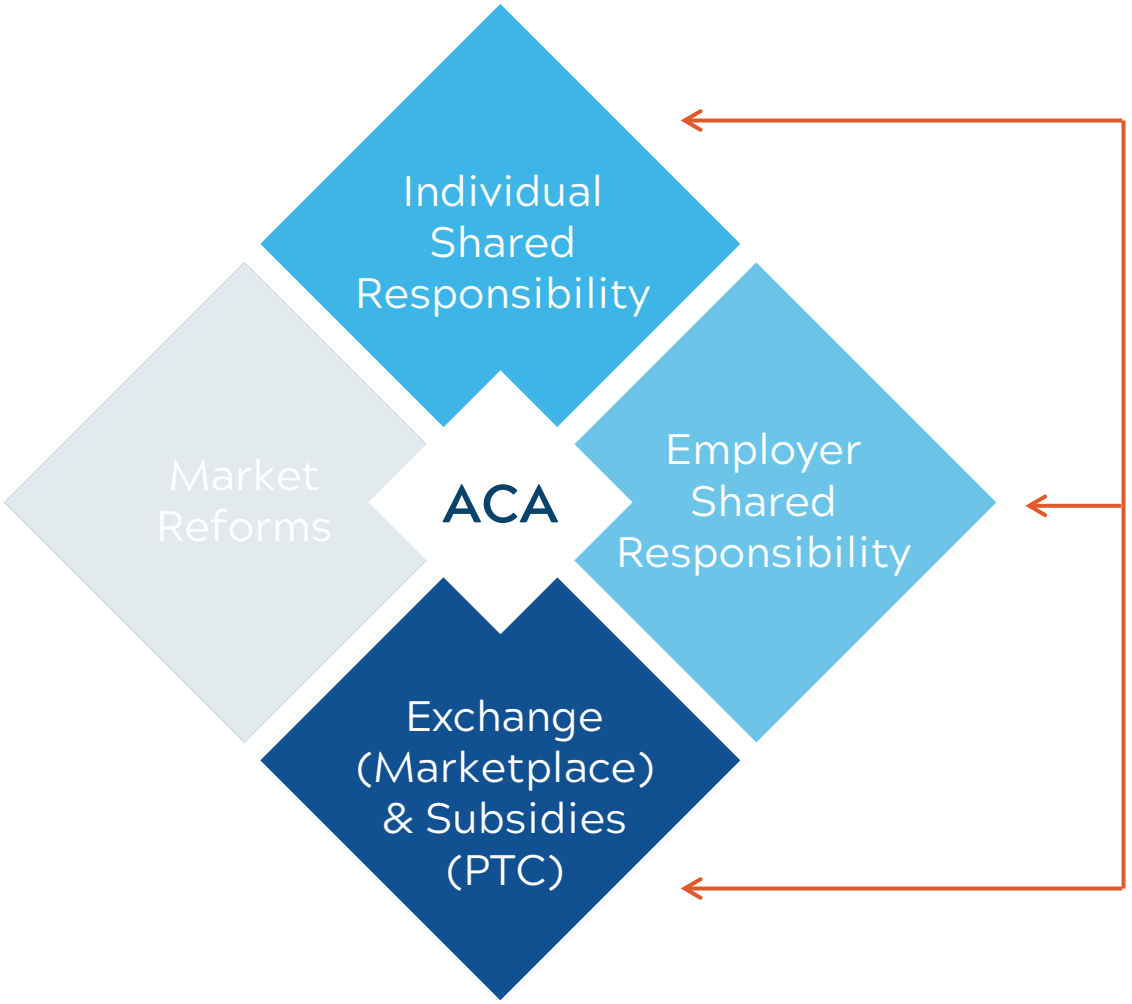
AFFORDABLE CARE ACT

1094 / 1095 Reporting

AFFORDABLE CARE ACT

Background

- **The 1094/1095 forms provide information that the IRS needs so it can administer:**
  - Penalties imposed under employer mandate
  - Eligibility for financial assistance (PTC) in the Exchange/Marketplace
- **Forms Employers use**
  - B Forms:
    - Small employers that sponsor self/level funded group health plans
  - C Forms:
    - All applicable large employers (ALEs) regardless of funding



1094/1095 Forms provide information applicable to these 3 provisions

AFFORDABLE CARE ACT

1094/1095 Reporting

Mandatory e-Filing Change

Old Electronic Filing Threshold

- MUST file 1094/1095 forms with IRS electronically if filing **250 or more** 1095 forms
- MAY file 1094/1095 forms with IRS electronically if filing **under 250** 1095 forms

New Electronic Filing Threshold

- MUST file 1094/1095 forms with IRS electronically if **filing 10+ tax forms**
- MAY file 1094/1095 forms with IRS electronically if filing under 10 tax forms
- Additional aggregation rule:
  - Forms are aggregated when counting and this includes any 1094/1095 forms as well as tax statements like Form 1099 and Form W-2 forms, but also Form 8027, Form 3921, Form 3922, Form 5498 and Form 1042-S
  - Because of aggregation, there will be very few employers allowed to file by paper instead of electronically.

1094/1095 Reporting

Mandatory e-Filing

- **Effective Date**
  - Effective for 2023 calendar year data
  - The 2023 forms 1094/1095 forms are filed in February/March 2024
- **Hardship Waivers**
  - Employers who wish to file a hardship request with hopes to still file by paper may do so by completing the 8944 form no later than February 15 of the reporting year
    - An important “hardship” factor would include the difference in cost between filing on paper and filing electronically

1094/1095 Reporting

Reminders - Deadline to furnish (to employees) permanently extended

- **Filing Deadline for 1095-C permanently extended**
  - Effective in 2023, the IRS permanently extended the deadline to furnish the 1095-B and/or the 1095-C form to employees
    - The extension is 30 days after January 31 (or 30 days after the next business day, if the 30th day falls on a Saturday, Sunday, or legal holiday).
    - Most years that means **March 2** unless the 30th day falls on a weekend
    - Consequently, there is no longer the option to file for an automatic 30-day extension

1094/1095 Reporting

Reminders - Good Faith Relief

- **Background**
  - Under 1094/1095 reporting penalties, IRS can impose penalties on employers for:
    - Failure to file/furnish the forms
    - Incorrect or incomplete forms
    - Late filing/furnishing the forms

- **No more "Transitional Good Faith" Relief**
  - The leniency for incorrect or incomplete forms no longer exists
    - Even if mistake is completely unintentional
    - Example of unintentional mistake: marking NO (did not offer to 95% FT employees) in column A on the 1094-C form instead of YES (did offer to 95% of FT employees)

1094/1095 Reporting

Reminders - Select Affordability Safe Harbor Each Year

- **Affordability Safe Harbors**
  - Two very important reasons an applicable large employer (ALE) should select an **affordability safe harbor** each plan year:
    - Avoid 1094/1095 Reporting penalties
    - Avoid Employer Mandate penalties
- **When**
  - Select when making decisions about contributions, just prior to the start of a new plan year
- **3 Options**
  - Three optional methods to “safely” ensure the ALE is offering at least one affordable plan
    - Federal Poverty Level (FPL) method
    - Rate of Pay method
    - W-2 Form method (not recommended generally)

AFFORDABLE CARE ACT

1094/1095 Reporting

Employer Mandate Penalties

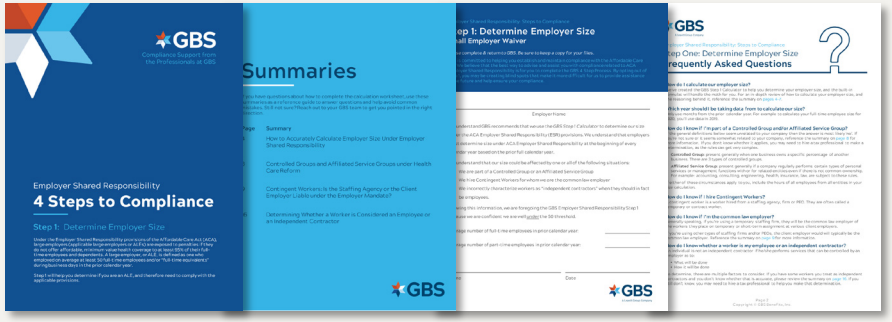
	Code § 4980H(a) non-offering penalty if owe all 12 months	Code § 4980H(b) affordability / minimum value penalty if owe all 12 months
2015	$2,080.00 X all FT employees (minus 30)	$3,120.00 X all FT employees who go to Marketplace / Exchange and obtain a subsidy
2016	$2,160.00 X all FT employees (minus 30)	$3,240.00 X all FT employees who go to Marketplace/Exchange and obtain a subsidy
2017	$2,260.00 X all FT employees (minus 30)	$3,390.00 X all FT employees who go to Marketplace / Exchange and obtain a subsidy
2018	$2,320.00 X all FT employees (minus 30)	$3,480.00 X all FT employees who go to Marketplace / Exchange and obtain a subsidy
2019	$2,500.00 X all FT employees (minus 30)	$3,750.00 X all FT employees who go to Marketplace/Exchange and obtain a subsidy
2020	$2,570.00 X all FT employees (minus 30)	$3,860.00 X all FT employees who go to Marketplace/Exchange and obtain a subsidy
2021	$2,700.00 X all FT employees (minus 30)	$4,060.00 X all FT employees who go to Marketplace/Exchange and obtain a subsidy
2022	$2,750.00 X all FT employees (minus30)	$4,120.00 X all FT employees who go to Marketplace/Exchange and obtain a subsidy
2023	$2,880.00 X all FT employees (minus30)	$4,320.00 X all FT employees who go to Marketplace/Exchange and obtain a subsidy
2024	$2,970.00 X all FT employees (minus30)	$4,460.00 X all FT employees who go to Marketplace/Exchange and obtain a subsidy

1094/1095 Reporting

GBS Tools

Employer Mandate

GBS 4 Steps to Compliance Toolkit



1094/1095 Reporting

GBS Annual Line-by-line Webinar

AFFORDABLE CARE ACT

1094/1095 Reporting

Penalty	2022 Tax Year (filed in 2023)	Original Amount
Failure to file/furnish an annual IRS return (1094-B or C) or to provide individual statements to all full-time employees (1095-C). This is per violation amount.	$290	$100
Annual cap on penalties	$3,532,500	$1,500,000
Lower cap for entities with gross receipts of not more than $5,000,000 (small employer)	$1,177,500	$500,000
Failure to file return or furnish statement when corrected within 30 days of required filing date (penalty per return/statement). This is per violation amount.	$50	$30
Annual cap on penalties when corrected within 30 days of required filing date	$588,500	$250,000
Lower cap for entities with gross receipts of not more than $5,000,000 when corrected within 30 days of required filing date (small employer)	$206,000	$75,000
Failure to file/furnish after 30 days and before August 1 of the year in which the required filing date occurs. This is per violation amount.	$110	$60
Cap on penalties when corrected by August 1 of the year in which the required filing date occurs	$1,766,000	$500,000
Lower cap for entities with gross receipts of not more than $5,000,000 when corrected by August 1 of the year in which the required filing date occurs (small employer)	$588,500	$200,000
Penalty (per filing/violation) in case of intentional disregard. No cap applies in this case.	$580	$250

1094/1095 Reporting

Reminders - State Rules

- **State-Specific Reporting**
  - Five states and the District of Columbia require annual state reporting
    - California, Massachusetts, New Jersey, Vermont, Rhode Island , District of Columbia (DC)
  - These requirements generally mirror, or are similar to, 1094/1095 reporting:

- **Why**
  - Most of these states established reporting requirements in response to the ACA Individual Mandate penalty adjustment ($0.00 penalty as January 2019) under the Tax Cuts and Jobs Act (December 2017)
  - Employers with employees residing in these states (and in DC) need to be aware they have state reporting obligations in addition to ACA reporting obligations. In most cases, but not all, the federal ACA 1094/1095 reporting forms can be used to satisfy these state requirements

Employer Steps

- Write down the reporting deadlines and plan in advance your reporting strategy (self-service or vendor)
  - E-filing forms through AIR system on your own is often not realistic because so technically complicated.
- If filed by paper in past, do not delay considering engaging (in advance) a reporting vendor to partially of full assist with mandatory electronic filing through AIR system. Ask your broker team for reference.
- Learn how to check your forms for accuracy (because no more good faith relief for unintentional mistakes)
- Complete GBS Step 3 Affordability Safe Harbor calculation and checklist EACH year BEFORE finalizing contributions decisions (just prior to beginning of new plan year)
- Complete GBS 4 Steps if have not already done so
- Check to see if any employees in states that required state “individual mandate” type rules

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1094 / 1095 Reporting

Resources

- 2022 reporting instructions for 1094/1095 C forms
- Final regulations permanently extending deadline to furnish to employees
- GBS Reporting Webinar

GBS summary: State-Specific Individual Mandate Rules and Annual Information Reporting Requirements

AFFORDABLE CARE ACT

Section 1557 Non-Discrimination

Section 1557 Non-Discrimination

Background

- **Rule**
  - Section 1557 prohibits certain health programs that receive fed**eral funding** from **discriminating** (excluding or denying benefits) based on race, color, national origin, age, disability, or **sex**

- **Litigation**
  - Section 1557 as well as the regulations HHS published to implement Section 1557, have been the subject of numerous lawsuits since 2016
  - The litigation has primarily focused on:
    - Which health programs and activities are subject to the rule
    - Whether "sex" discrimination includes discrimination based on gender identity, dysphoria and sexual orientation

- **Enforcement**
  - The rule is enforced by HHS Office of Civil Rights (OCR)

AFFORDABLE CARE ACT

Section 1557 Non-Discrimination

Applies to:

- **Fully insured plans**
  - Carriers/insurers typically receive **federal funding**

Does not (usually) apply to:

- **Self/level funded plans**
  - TPAs for self/level funded plans typically do not receive federal funding
  - Double check with TPA
    - For example, some TPAs have received federal funding as result of COVID

Section 1557 Non-Discrimination

Why Employers should pay attention even if Section 1557 does not apply to their plan

- **Even if Section 1557 does not apply, a separate rule, Title VII of the Civil Rights Act (1964) could apply**
  - Title VII:
    - Applies to ALL employers with 15+ employees
    - Makes it unlawful for an employer to discriminate against any individual as to compensation, terms, conditions, or privileges of employment based on an individual's race, color, religion, sex, or national origin.
    - Is enforced by the Equal Employment Opportunity Commission (EEOC)
- **Recent decisions**
  - Judges in various cases, as well as the EEOC in regulatory enforcement procedures with group health plans, have concluded that group health plans in question that did NOT cover procedures and services related to gender identity, dysphoria and sexual orientation were discriminating based on based on sex
    - Conclusions and findings were based on Section 1557 and/or under Title VII
- **Impact on employers that do not include coverage for these services**
  - Possible costly legal (litigation) and/or regulatory investigations/enforcement via OCR or EEOC

Employer Steps

Although this area is currently unsettled, there is still potential risk. It is valuable to be proactive and review plan documents now to discover whether the group health plan includes coverage for procedures and services relating to gender identity, dysphoria and sexual orientation. If not included:

- Determine whether section 1557 applies to your group health plan
- Even if does not apply, consider risk/exposure under Title VII of the Civil Rights Act
- Assess your risk tolerance given answers to the above and make applicable adjustments to the plan

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Section 1557 Non-Discrimination

Resources

- HHS page - Section 1557 of the Patient Protection and Affordable Care Act
- Proposed Rule - Nondiscrimination in Health Programs and Activities
- HHS Notification f interpretation and enforcement June 2021

AFFORDABLE CARE ACT

Preventive Services

Preventive Services

Background

- **Preventive Services**
  - These provisions require most health plans to cover a range of preventive services at no cost

Preventive Services Categories

1. Evidence based screenings and counseling
2. Routine immunizations
3. Preventive services for women *(mainly associated with pregnancy and violence against women)*
4. Preventive services for children/youth

Organizations Issuing Guidelines

1. U.S. Preventive Services Task Force (USPSTF)
2. Advisory Committee on Immunization Practices (ACIP)
3. Health Resources and Services Administration (HRSA)

Preventive Services

Intent

- **Save/improve health and costs through prevention**
  - Identifying illnesses earlier, managing them more effectively, and treating them before they develop into more complicated, debilitating and costly conditions

Applies To

- **Most all employer sponsored group health plans of any size and funding type**
  - Fully insured and level/self-insured group health plans in the individual, small group, and large group markets
  - Exceptions
    - Plans that maintain ACA “grandfathered” status are not required to comply
- **Exchange/Marketplace individual and small group plans**
  - This is required due to ACA Essential Health Benefits rules

Preventive Services

Legal Challenges

- **Past Issues**
  - From almost the beginning of implementation of this provision, there have been legal challenges, most associated with preventive services for women
    - Example: whether religious organizations must provide contraception at no cost

- **Recent Decision in Federal District Court**
  - On March 30, 2023, a Federal District Court judge in Texas issued a ruling that the requirement to provide preventive care as recommended by the U.S. Preventive Services Task Force (USPSTF) is unconstitutional
  - Impact
    - Voids Preventive Services with A or B rating recommended after ACA (March 2010) by USPSTF
    - Does not void:
      - Coverage requirements with A or B rating recommended by the USPSTF *prior* to ACA
      - Coverage requirements recommended by the other 2 bodies ACIP and HRSA
  - The federal government appealed this decision with the 5th Circuit Court of Appeals and requested a stay pending litigation

Employer Steps

Current Requirements

- **Must continue to cover, without cost sharing, preventive care items and services:**
  - Recommended by the USPSTF **before** March 23, 2010 with an A or B rating
  - Recommended by the ACIP and HRSA even if those same preventive care items and services were recommended with an “A” or “B” rating by the USPSTF

Current Options

- **May continue to cover, without cost sharing, items and services:**
  - Recommended by the USPSTF **after** March 23, 2010 with an A or B rating
- **HDHP Rule**
  - May continue to provide coverage for preventive care items and services with an “A” or “B” rating recommended by the USPSTF before individuals satisfy the minimum annual deductible

Employer Steps

No steps if you want to sit tight and wait out the resolution of this issue. Your group health plan can decide to make no changes for now and continue offering all recommended preventive services including those that were voided by the decision.

- If you want to make changes now, and NOT cover certain preventive services, the only changes allowed are those services recommended by the USPSTF after March 23, 2010 with an A or B rating. Talk to your TPA to determine whether/how/when those changes will be made.
- Employers considering changes to their plan's preventive health services coverage should proceed with caution since they may still be required to cover the full scope of recommended preventive services under other legal and contractual requirements. For instance, Braidwood does not affect state-law requirements, and the terms of contracts may prevent mid-year changes.

**GBS Compliance Team will be monitoring and updating you on this ongoing litigation as it works its way up to the Supreme Court.*

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Preventive Services

Resources

- Case: United States District Court Northern District Of Texas Fort Worth Division
- DOL FAQs
- An excellent KFF summary
- CMS page on Preventive Services
- Healthcare.gov Preventive Services
- List of Preventive Services for all adults
- List of Preventive Services for women
- List of Preventive Services for children/youth

Consolidated Appropriations Act of 2023

GBS Annual Conference

Health Benefits Compliance 2023

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Consolidated Appropriations Act of 2023

- **Background**
- **Mental Health Parity**
  - Non-federal government plans can no longer opt
  - Increase in enforcement funding
- **Telehealth and HSA/HDHP**

Background

What

- Each year Congress passes Appropriations Acts that provide (budgetary) authority to expend federal funds for specific and various purposes.
  - Appropriations generally address a wide variety of issues
  - Sometimes these rules affect group health plans

Examples of Prior CAA

- The **CAA of 2021** (passed December 2020) included the No Surprises Act, additional transparency provisions, and Mental Health Parity requirements
- The **CAA of 2022** (passed March 2022) extended the CARES Act provision that provided telehealth relief - and allowed an HSA to provide first dollar telehealth coverage without losing eligibility

The CAA of 2023

- The **CAA of 2023** (passed December 2022):
  - Extends the CARES Act temporary telehealth rule
  - Increases Mental Health Parity enforcement

CONSOLIDATED APPROPRIATIONS ACT (CAA) OF 2023

Mental Health Parity

CONSOLIDATED APPROPRIATIONS ACT (CAA) OF 2023

Mental Health Parity

Background

- **The Rule**
  - Mental Health Parity and Addition Equity Act (MHPAEA) prohibits a group health plan from offering mental health and substance use disorder benefits and services that are more restrictive than those applied to the plan's medical and surgical benefits

- **Three Types of Benefits**
  - Financial requirements
    - Deductibles, co-payments, coinsurance, and out-of-pocket maximums
  - Quantitative treatment limitations (QTLs)
    - Number of treatments, visits, or days of coverage
  - Non-quantitative treatment limitations (NQTLs)
    - Limitation on benefits that are not expressed numerically

CONSOLIDATED APPROPRIATIONS ACT (CAA) OF 2023

Mental Health Parity

Background

- **Applies To:**
  - Large self/level-funded, fully insured, grandfathered, and non-grandfathered group health plans if the plan offers mental health and substance use disorder benefits
  - Small group insured plans are (indirectly) required to comply due to ACA essential health benefits rules

- **Exempt Plans**
  - Self-insured plans sponsored by employers with under 50 employees
  - Group health plans consisting only of excepted benefits
  - Retiree-only group health plans
  - Group health plans and health insurance issuers that are exempt (due to an increased cost)
  - Large self-funded state/local government plans that meet opt-out requirements

Mental Health Parity

Update on Changes to "Opt Out" Exception

- **Background: Exception Allowed Prior to CAA of 2023**
  - Large, self-funded state/local government employers were able to opt out of meeting parity ONLY if the plan:
    - Files a HIPAA Exemption Election with CMS prior to the beginning of each plan year
    - Provided a notice of opt-out to enrollees at the time they first enrolled and annually thereafter, and
    - Filed with CMS a certification that the opt-out notice has been provided to participants
- **New Rule: Exception Eliminated in CAA of 2023**
  - Large, self-funded state/local government employers are no longer able to opt out of complying
    - Plans that have not previously elected to opt out of the MHPAEA are no longer be able to submit an election requesting to opt out
    - Plans that previously elected to opt out are unable to renew their election once it expires
    - Collectively bargained agreements with existing opt-out subject to multiple collective bargaining agreements may extend their opt-out elections until the date on which the term of the last CBA expires.

Mental Health Parity

Update on Mental Health Parity Enforcement

- **Enforcement Background**
  - To improve enforcement, the **CAA of 2021** amended the MHPAEA to require group health plans to perform and document (and, if requested, provide a report) on the plan design and application of mental health parity rules
  - Details: What is included in Report
    - The REPORT must specifically include a plan's Non-Quantitative Treatment Limitations (NQTLs)
    - Examples of NQTLs include limitations/exclusions based on:
      - medical necessity
      - facility type
      - prior authorization
      - standards for admission to a provider network
    - The data gathered through these reports are used to compile in a summary report to Congress

CONSOLIDATED APPROPRIATIONS ACT (CAA) OF 2023

Mental Health Parity

- **Enforcement Background**
  - Details: Results of past Reports
    - Past reports reveal almost all group health plans do not meet parity, particularly NQTLs
    - Examples
      - Limitation or exclusion of applied behavior analysis (ABA) therapy or other services to treat autism
      - Restrictive billing requirements
      - Limitation or exclusion of medication-assisted treatment (MAT) for opioid use disorder
      - Preauthorization or precertification requirements
      - Limitation or exclusion of nutritional counseling

Mental Health Parity

Update on Mental Health Parity Enforcement

- **The Rule**
  - The **CAA of 2023** authorized $10 million to CMS to fund Mental Health Parity enforcement grants to states
    - Grant money is to be used for state enforcement efforts, particularly to request the nonquantitative treatment limitation ("NQTL") analysis
    - Funding to states is designed to improve AND increase plan compliance and enforcement consistency at the state level
- **Impact on Employers**
  - Additional enforcement funding is another example of an increasing federal level (and now state level) commitment to mental health parity enforcement

CONSOLIDATED APPROPRIATIONS ACT OF 2023

Employer Steps

If you are a large, self-funded state/local government employer and you are offering mental health services but not meeting parity because you think you don't have to:

- Work with your TPA to amend your plan and follow the additional steps below

If you are any other plan of any size and funding that offers mental health benefits:

- Check with insurer/TPA to understand how mental health benefits are administered
- Ask specifically about how NQTLs are administered
- Review and utilize the online DOL self-audit tool to check current compliance and make adjustments to fill in gaps

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Mental Health Parity

Resources

- CMS- How to identify NQTLs
- CMS - PowerPoint slides on Mental Health Parity
- DOL Self-audit tool
- CAA of 2021
- CMS CAA 2021 page

CONSOLIDATED APPROPRIATIONS ACT (CAA) OF 2023

Telehealth and HSA Eligibility

Telehealth and HSA Eligibility

Background

- **Tax-advantaged contributions to HSAs are not allowed unless the account holder is covered by a high-deductible health plan (HDHP) and doesn't have disqualifying non-HDHP coverage.**
- **Congress created temporary exceptions to this rule to facilitate the use of telehealth during COVID**
  - As of January 1, 2020 the **CARES Act** allowed high deductible health plans (HDHPs) compatible with health savings accounts (HSAs) to provide benefits for telehealth or other remote care services before plan deductibles were met without impacting HSA eligibility.
  - On March 15, 2022 the **CAA of 2022** was signed. It included an extension of the CARES Act telehealth relief and allowed the temporary extension to continue through end of 2022

The Rule

- **CAA of 2023 extends through 2024 existing (temporary) COVID relief**
  - HDHP/HSA telehealth coverage and "other remote care services" pre-deductible
  - Individuals to have stand-alone coverage for telehealth and "other remote care services" pre-deductible without impacting their ability to contribute to an HSA.

CONSOLIDATED APPROPRIATIONS ACT (CAA) OF 2023

Telehealth and HSA Eligibility

Reminder: There are Different and Separate Temporary Telehealth Rules Due to COVID

- **Public Health Emergency**
  - As mentioned under the Public Health Emergency section above, employers were temporarily allowed to offer stand-alone telehealth benefits to individuals who are not eligible for coverage under their group health plan.
  - This temporary leniency terminates at the end of the Public Health Emergency on **May 11, 2023**
  - If a plan opted to offer this, can continue (only) through the end of the current plan year.
- **The CAA of 2023**
  - The CARES Act, the CAA of 2022 and the CAA 2023 provide temporary leniency on HSA eligibility rules and telehealth
  - This temporary leniency terminates **December 31, 2024** unless it is extended again

Employer Steps

- Decide whether you want to offer HDHP/HSA telehealth coverage and “other remote care services” pre-deductible
- Employers that would like to take advantage of this relief will need to amend their plan to reflect how the deductible applies to telehealth during these different times periods. Employers must also issue an SMM or revised SPD that clearly communicates

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Telehealth & HSA Eligiblity

Resources

- 2020 Cares Act
- CAA of 2022
- CAA of 2023

Employer Action: To Do Checklist

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Health Benefits Compliance 2023

End of Covid Emergency Declarations

- Public Health Emergency
- National Emergency and Outbreak Period

Transparency Updates

- Prescription Drug and Health Care Spending Data Collection (RxDC)
- No Gag Clause Prohibition Compliance Attestation (GCPCA)
- Air Ambulance data collection (AADC)

Affordable Care Act Updates

1094/1095 reporting

- Mandatory electronic filing starting 2024
- *Reminders:*
  - Affordability safe harbor for reporting
  - State reporting

Section 1557

- Nondiscrimination

Consolidated Appropriations Act (CAA) of 2023

- Telehealth
- Mental Health Parity

Health Benefits Compliance in 2023

Questions?

Presented by Susan L. Grassli, J.D.
GBS Health Care Reform & Health Benefits Attorney

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Resources – Full URLs

End of COVID Emergency Declarations

- **General Resources**
  - https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-58
  - https://blog.dol.gov/2023/03/29/what-does-the-end-of-the-covid-19-public-health-emergency-mean-for-health-benefits
  - https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html
- **Participant Facing**
  - https://blog.dol.gov/2023/03/29/five-important-changes-to-your-health-coverage-once-the-covid-19-public-health-emergency-ends
- **Congressional Actions**
  - https://www.congress.gov/bill/118th-congress/house-bill/382/text
  - https://www.congress.gov/bill/118th-congress/house-joint-resolution/7/text

Prescription Drug and Health Care Spending Data Collection (RxDC)

- **General Resources**
  - https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection
  - https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf
  - https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-56
  - https://regtap.cms.gov/reg_librarye.php?i=4183
  - https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-56
  - https://www.congress.gov/bill/116th-congress/house-bill/133/actions
- **HIOS Resources**
  - https://www.youtube.com/playlist?list=PLaV7m2-zFKpi_dB7s4L2H2B1ZgSsNuLHv
  - https://regtap.cms.gov/reg_librarye.php?&i=3862
  - https://portal.cms.gov/portal/

Resources – Full URLs

No Gag Clause Prohibition Compliance Attestation (GCPCA)

- **Resources**
  - https://www.cms.gov/files/document/aca-part-57.pdf
  - https://hios.cms.gov/HIOS-GCPCA-UI
  - https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance
  - https://www.congress.gov/bill/116th-congress/house-bill/133/actions
- **Complaints**
  - https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint

Air Ambulance Data Collection (AADC)

- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Air-Ambulance-Data-Collection
- https://www.federalregister.gov/documents/2021/09/16/2021-19797/requirements-related-to-air-ambulance-services-agent-and-broker-disclosures-and-provider-enforcement
- https://www.congress.gov/bill/116th-congress/house-bill/133/actions

Exchange Subsidies and the Family Glitch

- https://public-inspection.federalregister.gov/2022-07158.pdf
- https://public-inspection.federalregister.gov/2022-22184.pdf
- https://www.govinfo.gov/content/pkg/FR-2013-02-01/pdf/2013-02136.pdf
- https://www.healthcare.gov/glossary/premium-tax-credit/

1094/1095 Reporting Resources

- https://www.irs.gov/pub/irs-pdf/f8944.pdf
- https://www.irs.gov/pub/irs-pdf/i109495c.pdf
- https://public-inspection.federalregister.gov/2022-27212.pdf
- https://gbsbenefits.com/watch-now-form-1094-1095-2022/

Resources – Full URLs

Section 1557 Non-Discrimination

- https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
- https://www.federalregister.gov/documents/2022/08/04/2022-16217/nondiscrimination-in-health-programs-and-activities
- https://www.federalregister.gov/documents/2021/05/25/2021-10477/notification-of-interpretation-and-enforcement-of-section-1557-of-the-affordable-care-act-and-title#:~:text=Section%201557%20prohibits%20discrimination%20on,Rights%20Act%20of%201964%20(Pub.

Preventive Services

- https://storage.courtlistener.com/recap/gov.uscourts.txnd.330381/gov.uscourts.txnd.330381.114.0.pdf
- https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-59
- https://www.kff.org/policy-watch/qa-implications-of-the-ruling-on-the-acas-preventive-services-requirement/
- https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/preventive-care-background
- https://www.healthcare.gov/coverage/preventive-care-benefits/
- https://www.healthcare.gov/preventive-care-adults/
- https://www.healthcare.gov/preventive-care-women/
- https://www.healthcare.gov/preventive-care-children/

Telehealth and HSA Eligibility

- https://www.congress.gov/bill/116th-congress/senate-bill/3548/text
- https://www.congress.gov/bill/117th-congress/house-bill/2471/text
- https://www.congress.gov/bill/117th-congress/house-bill/2617/text

Mental Health Parity

- https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/mhapeachecklistwarningsigns.pdf
- https://www.cms.gov/files/document/mhpaea-nqtl-presentation-health-insurance-issuers.pdf
- https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf
- https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf
- https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/caa