



HUB

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2024 Compliance & Benefits Update: How the New Transparency Rules Will Impact Your Organization

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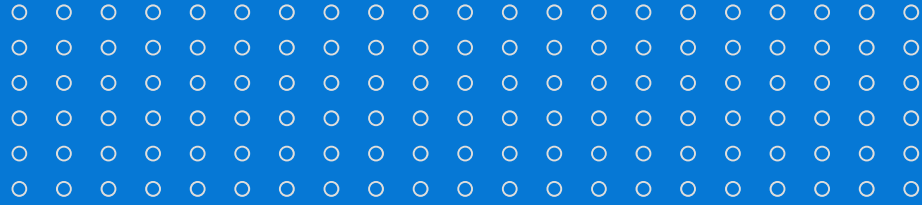
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Agenda

1. Employee-Centric Focus
2. Transparency & Access to Information
3. Benefits Offerings & Design
4. Financial Considerations
5. Mental Health and Benefits
6. Looking Forward



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Employee-Centric Focus



What Employees Want and Expect from Their Workplace

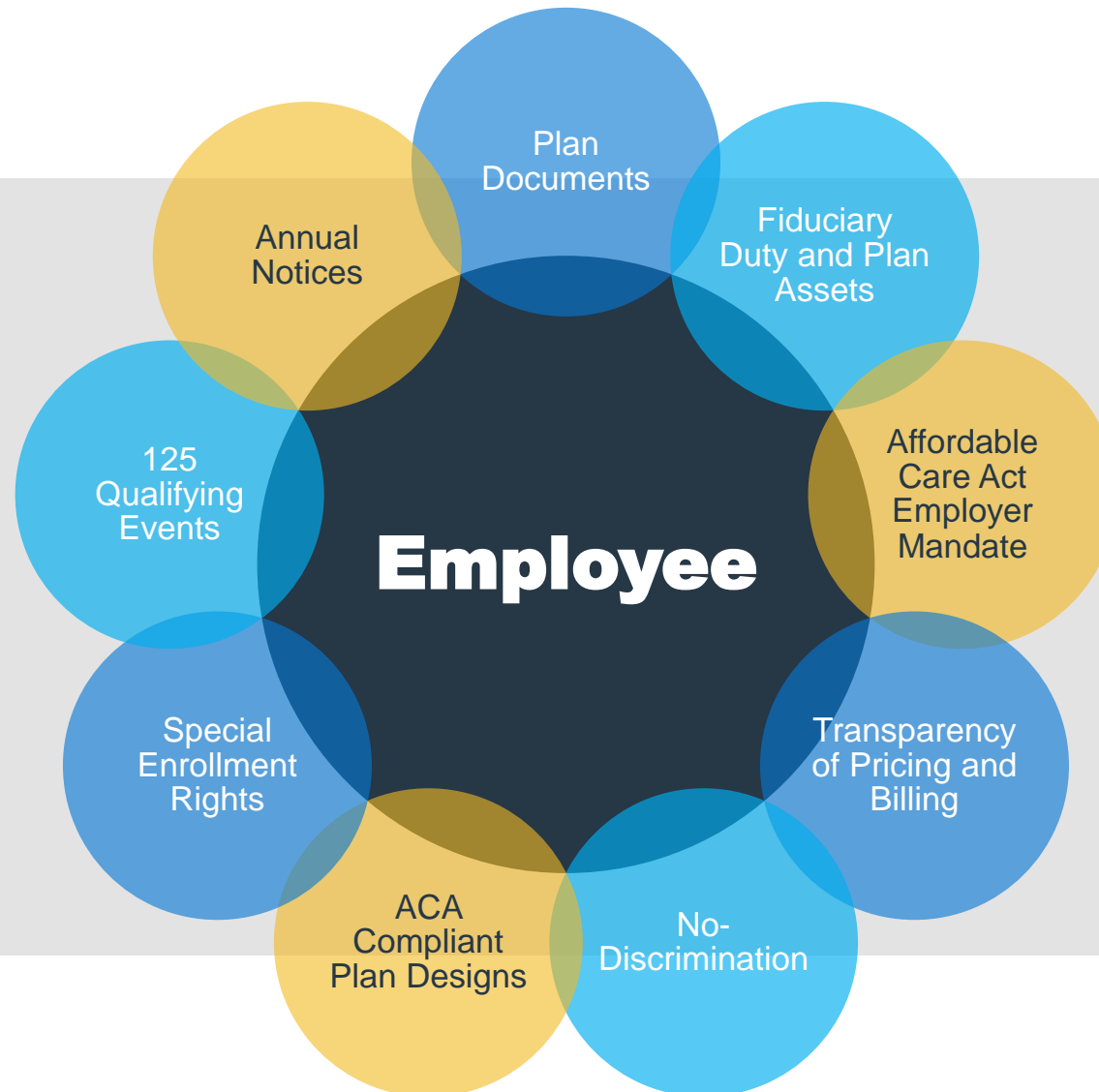
- **67%** of job seekers **consider workplace diversity an important factor** when considering employment opportunities, and more than **50%** of current employees **want their workplace to do more to increase diversity.**
<https://www.glassdoor.com/employers/blog/diversity/>
- **45%** of American **workers experienced discrimination and / or harassment** in the past year.
https://www.gallup.com/workplace/215939/invest-diversity-inclusion.aspx?utm_source=link_wwwv9&utm_campaign=item_236264&utm_medium=copy
- **78%** of employees who responded to a Harvard Business Review (HBR) study said they **work at organizations that lack diversity in leadership positions.**
<https://hbr.org/2013/12/how-diversity-can-drive-innovation>
- **Organizations with above-average gender diversity** and levels of employee engagement **outperform** companies with below-average diversity and engagement by **46% to 58%.**
<https://www.fastcompany.com/3067346/how-these-top-companies-are-getting-inclusion-right>

What Employees Need, Want and Expect from Their GHP

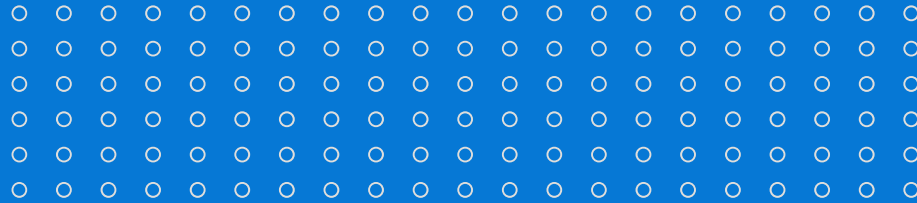
- No discrimination in plan design and administration
- Consistency in plan administration
- Understandable, accessible, and expedient claims processes
- Plain language explanations of employee and Plan Sponsor rights and obligations
- Affordable health insurance premiums and limited financial exposure for health events
- Ability to plan ahead and make informed decisions
- Certainty of costs
- Clear explanations of federal and state employee rights
- Proper use of employee contributions (i.e., Plan Assets)



Plan Administrator Compliance Obligations



2



Transparency & Access to Information



Transparency of Healthcare Costs



Employee Needs – transparency with employers builds employee trust and addresses financial stressors

Employer Obligations – Employers must provide the following to covered employees to meet the Health plan transparency requirements:

- Rates for all covered items and services between the plan or issuer and in-network providers
- Transparency re: out-of-network providers costs
- **Internet-based price comparison tool** allowing an individual to receive an estimate of their cost-sharing responsibility for a specific item or service from a specific provider or providers, for 500 items and services. The tool must also be available by phone or in paper form upon request
- While many of these do not tie directly to disclosure to employees, employers can highlight efforts in this area to demonstrate their commitment to transparency

CAA Transparency Requirements



Requirement	Machine-Readable Files	RxDC Reporting	Gag Clause Attestations
What	Post machine-readable files containing costs of INN and OON claims on external website	Report certain data related to prescription drug spend and overall plan expenses	Attest that provider / network agreements do not contain gag clauses prohibiting sharing of certain information
Who	Can be completed by carrier / TPA / PBM on behalf of plan sponsor, or may require plan sponsor to directly complete		
When	Ongoing	June 1, 2023 and thereafter	December 31, 2023 and thereafter
How	Posted on employer's website or website of carrier / TPA	Completed via the CMS HIOS platform	

Gag Clause – Attestation Requirements

Purpose: Prohibiting health plans from entering contracts with TPAs, network and service providers, or other parties that inhibit a plan's right to know cost or quality of care information.

When: December 31, 2023, reporting for 2021, 2022 and 2023 calendar years.

What: A plan or issuer must attest that it has not entered into an agreement that would directly or indirectly impose restrictions on the following:

1. Restrictions on the disclosure of 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;
2. Restrictions on electronic access to de-identified claims and encounter information or data for each participant, beneficiary, or enrollee upon request; and
3. Restrictions on sharing information or data described in (1) and (2), or directing that such information or data be shared, with a business associate, as defined in 45 CFR 160.103, consistent with applicable privacy regulations.

How is the attestation submitted?

Via the HIOS site: [Gag Clause Attestation | Welcome! \(cms.gov\)](#)

Action Item: Submission must be made on or before **12/31/23**. The employer or plan should retain documentation stating that the TPA / PBM / network provider did not have any gag clauses in their contracts since 2021.

Certainty in Billing and Costs

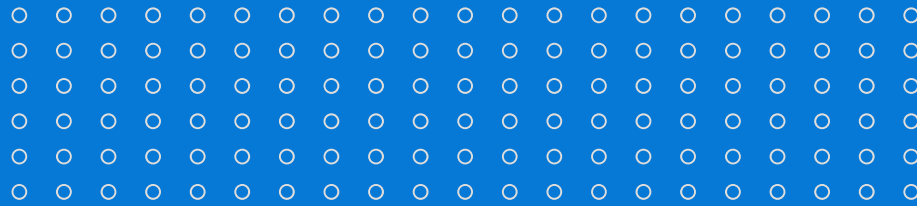


Employee Needs – protect participants from surprise medical bills and remove them from payment disputes between a provider or health care facility and their health plan – less stress and anxiety – builds trust

Employer Obligation – No Surprises Act requires plan sponsors provide participants:

- Plain-language notice explaining the protections against surprise billing
- Protection against ER and other certain services out-of-network billing
- Removes patients from health care provider / facility payment disputes through Independent Dispute Resolution (IDR) process
- Good-faith estimates of medical items or services for uninsured (*or self-paying*) individuals.
- Establishing a patient-provider dispute resolution process for uninsured (*or self-paying*) individuals
- Additional claims appeals processes

3



Benefits Offerings and Design



Benefits Offered Fairly and Equally



Employee Needs – Diversity and inclusion – fosters employee trust and demonstrates fairness

Employer Obligation – IRS §125 non-discrimination and IRS §105(h) non-discrimination;
Bostock; ACA §1557

- Cannot discriminate in favor of highly-paid employees
 - Eligibility, contributions and benefits
- Nontaxable benefits provided cannot disproportionately benefit key employees
- Consideration of various populations
 - Gender transition
 - Accommodations for disabled employees
 - Bilingual needs
 - Pregnant employees
- Same plan coverage regardless of sex orientation, gender, or any other class / demographic

New proposed rules were released in 2022

- **The new rules largely go back to pre-Trump Administration rules, with some changes:**
 - An expanded definition of entities covered under the rule so that if an entity receives **any** federal financial assistance, **all** of its operations would be subject to Section 1557
 - The proposed rules have a specific list of communications that must include the taglines (*e.g., HIPAA privacy notice, EOBs, etc.*)
- ➔ **Rules may be finalized in 2024, so plans may be required to send the notices again**
 - ***C.P. v. Blue Cross Blue Shield of Ill. Section 1557***
 - Court ruled that a TPA was subject to Section 1557 even though plan sponsor was not, because TPA receives federal funds
 - The ruling greatly expands Section 1557 scope and is likely to be challenged.

Bostock, Title VII, and Group Health Plans

Title VII applies to all terms and conditions of employment including employee benefits

In *Bostock*, the U.S. Supreme Court decided that Title VII protections extend to homosexual and transgender employees.

Denying healthcare coverage “because of” sex would seem to unquestionably violate Title VII because those benefits are “compensation, terms, conditions, or privileges of employment” under the Act.

“[T]here is no reason to believe that Congress intended a special definition of discrimination in the context of employee group insurance coverage.”

Lange v. Houston County, GA, et al., M.D. Georgia, June 2, 2022

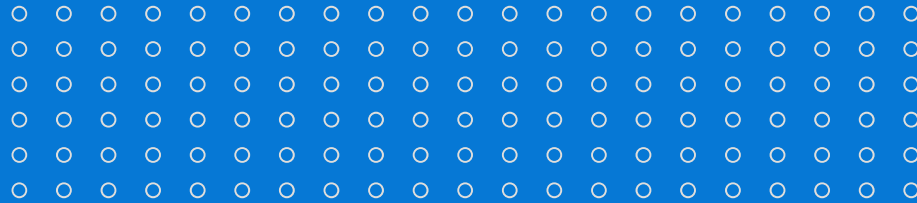
Two federal district courts (one in Georgia, one in North Carolina) have said *Bostock* applies to benefits and denying gender-affirming care would be a violation.

This could result in additional litigation and / or rulemaking that would result in plans being required to provide gender transition benefits (see also the discussion of ACA 1557 earlier). More lawsuits have been filed and are making their way through the courts.

Dobbs – Supreme Court Decision

- Overturned *Roe v. Wade*
- Abortion access no longer protected – determined by state
- Many states have sought limits based on duration of pregnancy, when the mother's health is in imminent danger, etc.
- Some states posed the question to voters only to see surprising outcomes in favor of protecting abortion access – KS and OH
- Insured plans are governed by state law, so many may already exclude elective abortion
- Self-insured plans can choose to cover elective abortion, but employees may not have access to abortion in their home states

4



Financial Burdens



Financially-Accessible Health Plans



Employee Needs – addresses employee’s financial stress and removes enrollment obstacles

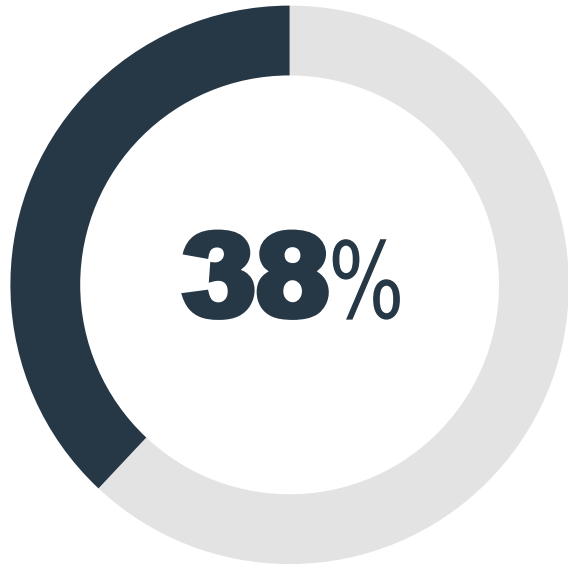
Employer Obligation – Affordable Care Act affordability employer mandate

- Employee premium contributions are “affordable” based on their annual W-2 compensation, rate of pay, or the federal poverty level

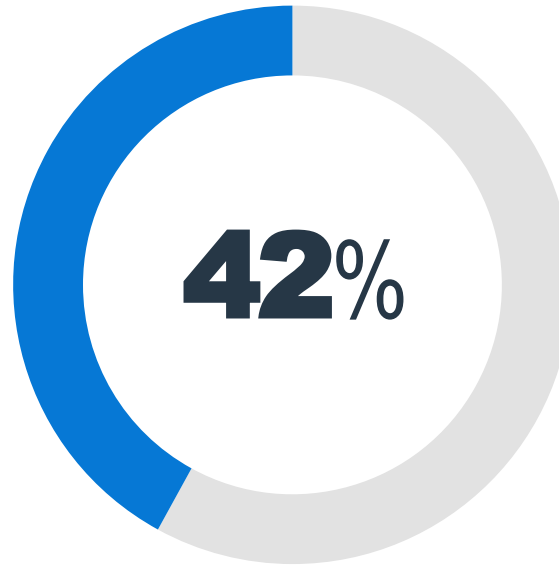
Why Employees Leave Their Jobs



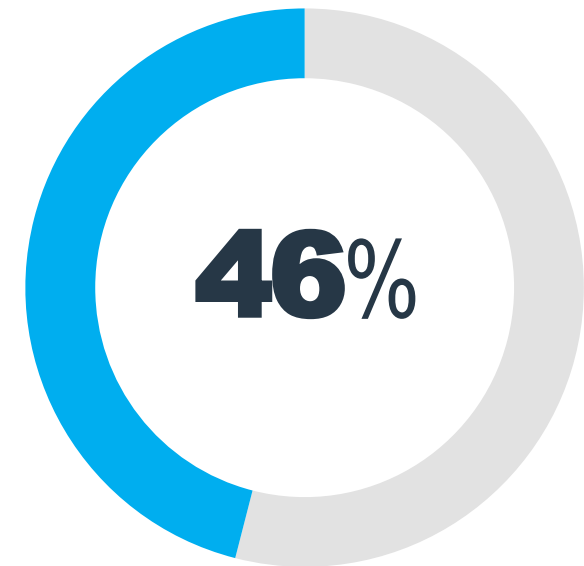
In the Top 3:



Struggle to pay the bills every month



The proportion of workers **planning to ask for a pay increase** jumped from 35% to 42% year over year



Among workers who are struggling financially, **that number rises to 46%**

Affordability of Employee-only Coverage

Lowest cost plan that is **minimum value**. **Safe harbor decreased from 9.12% to 8.39%** based on one of the three safe harbors:

1 Rate of Pay

(Hourly rate of pay x 130)

8.39% Maximum amount to charge for employee-only coverage will decrease from 2023 to 2024

- **Example:** An employee earning \$13.00 an hour in 2023 cannot pay more than \$154.13 per month if the plan is to be deemed affordable; however, in 2024, that same employee cannot pay more than \$141.79.

2 Federal Poverty Level (FPL)

Calendar year plans must use **2023 FPL x 8.39% / 12** to assess affordability for 2024
 $(\$14,580 \times 8.39\% / 12) = \underline{\$101.94}$
vs. the 2022 rate of \$103.28 per month.

- Non-calendar year plans unknown as 2024 FPL guidelines have not been issued

3 W-2 Safe Harbor

Use Box 1 of employee's W-2 earnings.

Must use projected 2024 income; amount cannot change throughout the year.

- Box 1 = gross earnings minus pre-tax deductions under a cafeteria plan and a 401(k) plan

2024 Affordability Observations



2024 is the second consecutive year with a new record low percentage

Employers who based 2023 affordability on the maximum allowable percentage will need to increase employer contributions to meet 2024 affordability

Employer contributions must be **further increased** to offset premium increases

The increase in the Federal Poverty Level from 2022 to 2023 (*which calendar year 2024 plans use for affordability*) does not offset the decrease in affordability – employee rates must still be lowered

Beware of economy-driven changes in compensation that may impact affordability under W-2 safe harbor – sales positions, businesses sensitive to interest rates, etc.

Strategies for Dealing with Affordability Decline



- Increase employer contributions
- Increase employee contributions to other benefits
- Offer a plan that isn't affordable under the ACA definition (*potential "B" Penalty exposure*)
- Plan design changes
- Tiered contributions (*richer contributions to lower-paid employees*)
- Individual Coverage HRAs (*ICHRA*)

Penalties Through the Years



		2020	2021	2022	2023	2024
4980H(a) Penalty	Annual Amount	\$2,570.00	\$2,700.00	\$2,750.00	\$2,880.00	\$2,970.00
	Monthly Amount	\$214.17	\$225.00	\$229.17	\$240.00	\$247.50
	MEC Offer % of FT	95%	95%	95%	95%	95%
	FT Headcount Reduction	30	30	30	30	30
4980H(b) Penalty	Annual Amount	\$3,860.00	\$4,060.00	\$4,120.00	\$4,320.00	\$4,460.00
	Monthly Amount	\$321.67	\$338.33	\$343.33	\$360.00	\$371.67
	Affordability Safe Harbor %	9.78%	9.83%	9.61%	9.12%	8.39%
	FPL Annual Amount (individual)	\$12,760.00	\$12,880.00	\$12,880.00	\$13,590.00	\$14,580.00
		Current Enforcement				No good faith

IRS Enforcement of ESRP- Letter 226J

The current Administration brought enhanced focus on ACA enforcement efforts from the IRS

IRS is currently auditing employer compliance with the **2020/2021 ESRP** provisions of the ACA

- Letters 226-J mailed to employers informing them of failure to comply with IRS 4980H(a) or (b) provisions and a proposed employer shared responsibility penalty (ESRP)
- Letter provides employer 30 days to respond to the inquiry. The Employer can do one of the following:
 - Employer agrees and pays penalty
 - Employer appeals the penalty and supports additional information with the appeal

The employer should file an extension with the IRS to appeal the assessed penalty by faxing a request to the number on right-hand corner of the letter 226-J. The employer will be granted a 30-day extension to appeal their assessment.

NEW: Letters 226J now also question if a plan is deemed to be affordable under the ACA, using new codes on the Form 14765. The employer is required to show proof that plans are deemed to be affordable.

ACA Reporting – Reminders for 2024



Remember: Self-insured medical plans, including MEC and ICHRA plans sponsored by employers of any size are required to comply with ACA reporting requirements. Self-insured medical plans must comply with federal and state individual mandate reporting requirements.

Who is required to report?

- 1. Issuer of MEC:** Self-insured medical plans including MEC, ICHRAs and level-funded plans sponsored by **employers of any size**. Must report the months an employee and covered dependents were enrolled in the group health plan. Insurance carriers will comply with the reporting requirements for insured medical plans.
- 2. Applicable Large Employer (ALE):** An employer who employed on average 50 FT or FTE employees in the prior calendar year (2022). Must report the offer of coverage made, the cost of coverage and if the FT employee elected or waived enrollment in coverage.

What Forms are Covered Employers Required to use?

- 1. Self-insured (including MEC and ICHRAs) or level-funded employer with less than 50 FT and FTE employees:** Must use Form 1094 and 1095-B to report the months employees and dependents were covered by a self-insured/level funded group health plan.
- 2. Self-insured (including MEC and ICHRAs) or level funded employer who is an ALE:** Must use Forms 1094/1095-C must complete Parts I, II and III of the Form 1095-C. Part III it reports the months the employee and dependents, COBRA QB and retirees were enrolled in the group health plan.
- 3. Fully-insured employer who is an ALE:** Must use Forms 1094/1095-C, must complete only Parts I and II of Form 1095-C.

ACA Reporting – Reminders for 2024

When are the returns due?

- **IRS Deadlines:**
 - ➔ Distribute Forms 1095-C to employees: **March 1, 2024**
 - ➔ File Forms 1095-B & -Cs with the IRS (*electronic*): **April 1, 2024**
 - ➔ File Forms 1095-B & -Cs with the IRS (*paper*): **February 28, 2024**, noting that if an **employer files 10 or more returns** (*any return W-2, 1099, other*) they will be **required to e-file all returns**.
- **State deadlines – Vary depending on the state, refer to state chart for additional details.**
 - **CA, MA and RI** – Forms must be distributed to employees / participants by **January 31, 2024**.
 - Self-insured/level-funded plans must comply with federal and state reporting requirements. Compliance with federal reporting requirements does not exonerate plans from complying with state reporting requirements.

What should clients be doing now?

- Reviewing ACA reporting codes to ensure their ACA reporting software is capturing the coding methodology to apply to returns
- Review pre-populated forms to ensure they are coded correctly
- Suppressing forms for non-FT employees (*unless plan is self-insured / level-funded and coverage is offered to PT employees*)

State Individual ACA Reporting Mandate Deadlines



Insurance carriers, self-funded *and* level-funded medical plans (ICHRAs, level-funded and MEC plans) covering residents in 2023 – REPORTED in 2024

California

- 1095 C/B mailed to employees by **January 31, 2024**
- 1095 C/B filed with State of CA Franchise Tax Board by March 31, 2024
- File the State Healthcare MEC on paper if under 250 files; otherwise, must file electronically
- Mandated distribution deadline is not automatically extended to mirror the federal deadline.

Massachusetts

- Distribute Form MA 1099-HC annually to employees enrolled in their health plan no later than January 31, 2024
- Complete HIRD Form for Six (6) or more employees and submit each year on December 15th of the reporting year
- Will be required to file on [MassTaxConnect \(MTC\)](#) portal

New Jersey

- 1095 C/B to be distributed to employees by **March 1, 2024**
- File NJ-1095 form by **March 31, 2024**, with the New Jersey Division of Taxation [Payroll Taxes and Wage Withholding Login \(state.nj.us\)](#)

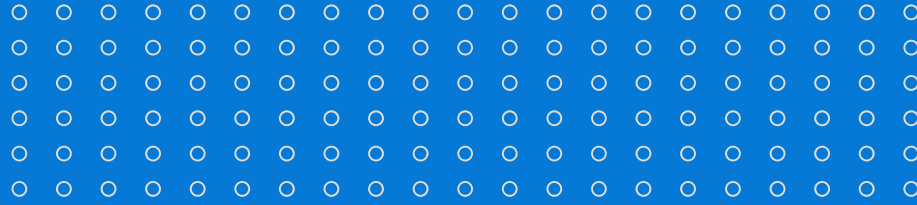
Rhode Island

- Forms 1095-C/B must be distributed to covered participants by **March 1, 2024**
- Forms 1095 C/B must be filed with the [RI Division on Taxation](#) by March 31, 2023, giving employers a two (2) month extension from the January 31, 2024, deadline

Washington D.C.

- Employers that have a Washington D.C. residence and have 50 or more employees
- Forms 1095-C/B must be distributed to covered participants as outlined by [IRS, including any extensions](#)
- 1095 C/B must be filed with the Office of Tax and Revenue no later than 30 days after the deadline established by the [IRS to file returns, including extensions](#).
- Electronically-submitted only [D.C Office of Tax and Revenue \(OTR\) electronically through MyTaxDC](#)

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Mental Health and Benefits



Mental Health Coverage

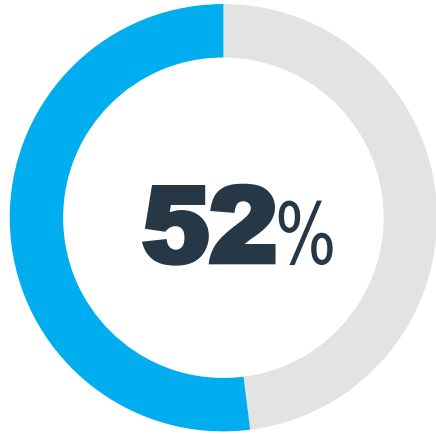


Employee Needs – access to affordable mental health care, addresses employee engagement and in some cases quiet quitting

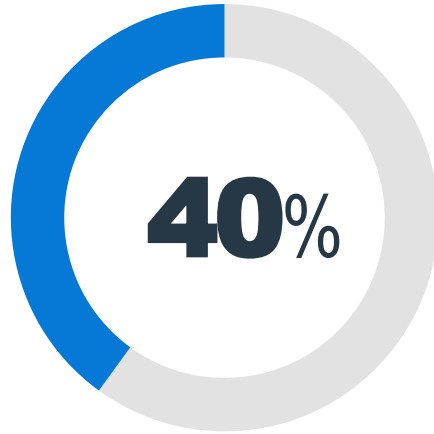
Employer Obligation – Mental Health Parity

- Accessible benefits for mental health / SUD and general medical care
- Benefits that are responsive to both federal requirements and employee needs
- Programs and offerings that address the current US mental health crisis

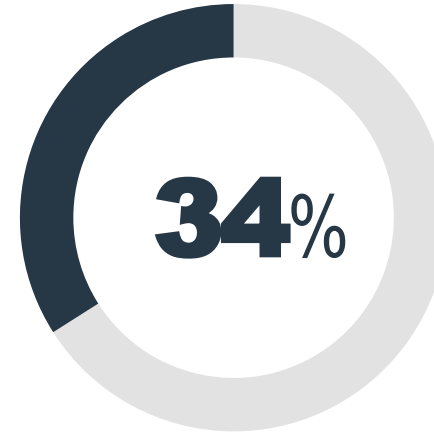
Mental Health and the Workplace



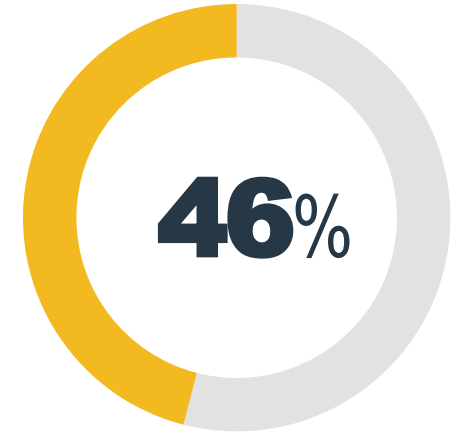
report that they **experience stress for “A lot of the day”**



of employees **agree that their company invests in developing supportive managers**



of employees **state that their company’s leadership speaks openly about mental health**



of companies **provide mental health training**

Companies that invest in developing supportive managers are correlated with **overall healthier workplace** scores.

Company **leadership speaking openly about mental health** and providing mental health training **raises employee awareness about resources at work.**

NQTL Comparative Analysis



DOL audits will keep coming!

The NQTL analysis does not have to be filed or provided to the government, but after February 10, 2022 the Department of Labor (*DOL*) or Health and Human Services (*HHS*), or state enforcement authorities, could start requesting reports from employers and carriers.

Requirement: Group health plans / health insurance issuers that offer both M/S and MH/SUD benefits and impose NQTLs on MH / SUD benefits, must conduct and document a comparative analysis of the design and application of their nonquantitative treatment limitations (“NQTLs”)

What is my NQTL deadline? The CAA specifies that group health plan NQTL results must be documented and ready to hand over to the government. It also requires the government to audit and report findings as well as create and update guidance documents.

Initial Review. The initial report from the government showed that **no** plan sponsors (*out of 150+*) generated a compliant report. Lobbying groups are actively pushing the agencies for clearer guidance on what a compliant report looks like.

In EBSA's last report to Congress, they indicated that they closed NQTL investigations on 3 plans covering over 5,700 participants between November 2021 and July 2022

The top 2 NQTLs resulting in determination letters:

1. Exclusion of ABA therapy, cognitive, intensive behavioral, habilitative or rehabilitative interventions to treat MH / SUD
2. Prior authorization, precertification

Example of a Correction and its Impact



Removal of Exclusion of Coverage for MH / SUD Telehealth Benefits

- **Issue:** A self-funded plan excluded MH / SUD benefits provided via telephone, email, or internet. The plan did not have any similar restrictions on medical / surgical benefits.
- **Action:** EBSA's Cincinnati Regional Office issued an initial determination of non-compliance to the plan, citing the exclusion as an impermissible NQTL.
- **Result:** The plan removed the impermissible NQTL and notified participants of the change in plan terms. Approximately 2,000 participants now have access to MH / SUD telehealth benefits as a result of the correction.

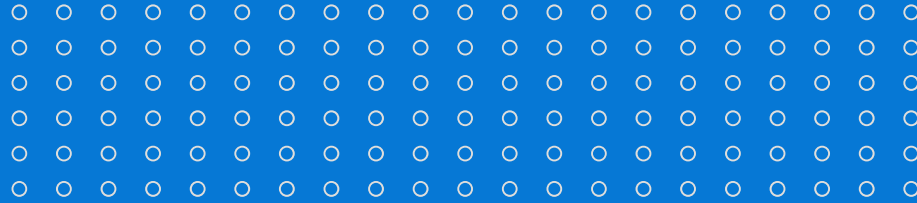
Example of a Correction and Its Impact



Ending the Use of an EAP as a Gatekeeper for MH / SUD Services

- **Issue:** When participants of a multiple-employer welfare arrangement plan sought MH / SUD benefits by calling the phone number on their plan membership card, they were connected directly to the plan's EAP provider. The EAP call operators acted as gatekeepers, using prescreening questions to decide whether to direct participants to EAP counselors or to refer them to the plan's network provider for MH / SUD services. The plan did not use the EAP or any other comparable program or entity as a gatekeeper for any medical / surgical benefits.
- **Action:** EBSA's Los Angeles Regional Office issued an initial determination of non-compliance to the plan, citing the practice of using the EAP as a gatekeeper for accessing MH / SUD benefits as an impermissible NQTL.
- **Result:** The plan ended the practice of using the EAP as a gatekeeper for MH / SUD benefits. It removed the NQTL from plan documents and issued new membership cards with amended information allowing participants to contact MH / SUD providers directly without going through the EAP. This correction affected over 4,000 participants who will now be able to directly access MH / SUD benefits through the plan's network provider for MH/SUD services.

6



Looking Ahead



A Congress Divided

- Republicans control the House; Democrats control the Senate
- Major legislation is very unlikely
- Some minor changes around the edges may occur

More Regulation

- With expected gridlock in Congress, the Biden Administration will look to regulate more early in the year
- **Reminder:** Executive Orders themselves are of no effect until acted on by agencies
- Rules / guidance from agencies likely to be challenged
- Rules will try to be finalized by August to avoid potential challenges under Congressional Review Act

ACA Preventive Care Lawsuit



- *Braidwood Management Inc. v. Becerra* challenged certain ACA preventive care requirements, which all non-grandfathered plans must cover at 100%
- Preventive requirements from the United States Preventive Services Task Force (*USPSTF*) were deemed to be unconstitutional in violation of the Appointments Clause, which says that legally-significant government decisions must be made by federal officers who are appointed by the President or by a department head
- Case specifically targeted the requirement that plans cover pre-exposure prophylaxis (*PrEP*) drugs that prevent transmission of HIV on religious freedom grounds
- Nationwide injunction issued, but case will be appealed, likely heading to the Supreme Court
- Plans theoretically do not have to cover preventive requirements determined by the *USPSTF*, though pending the outcome of the case, exclusions will be difficult practically
- Look for announcements from carriers / TPAs

Employees at the Center of your Employee Benefits Compliance



What Employees Need, Want and Expect

- Benefits Offered Fairly and Equally
- Benefits Administered Consistently
- Frictionless Claims Processes
- Easy to Understand Plan Explanations
- Financially-Accessible Health Plans
- Comprehensive Health Coverage
- Transparency of Healthcare Costs
- Certainty in Billing and Costs

Fiduciary Duties



Q&A

Thank You

For more information visit hubinternational.com

