healthgram

Q2 2021 Compliance Update

Service Provider Compensation Disclosures as Outlined in the Consolidated Appropriations Act, 2021

Status:
The Consolidated Appropriations Act, 2021 (CAA), was signed into law on December 27, 2020 and includes provisions to increase transparency in employee health benefit plans.

What it is:
The "Transparency Provisions" outlined in the CAA encompass four key areas, including:

- Prohibition on Gag Clauses;
- Disclosure of Compensation;
- Parity NQTL Analysis; and
- Reporting on Pharmacy Benefits and Drug Costs.

In this article, we'll focus specifically on Division BB, Title II, Sec. 202 of the CAA (pp. 2008-2023): Disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans on the individual market.

What you need to know:

- Per Division BB, Title II, Sec. 202 of the CAA (pp. 2008-2023), effective 27 December 2021, Service providers must disclose to plan fiduciaries upfront (i.e. at time of contracting) a description of:
  - The services to be performed; and
  - Any direct or indirect compensation that they reasonably expect to receive for the brokerage or consulting services.
    - The term "service provider" means a service provider that enters into a contract or arrangement with the covered plan and reasonably expects $1,000(or such amount as the Secretary may establish in regulations to account for inflation since the date of enactment of the Consolidated Appropriations Act, 2021, as appropriate) or more in compensation, direct or indirect, to be received in connection with providing one or more services, pursuant to the contract or arrangement, regardless of whether such services will be performed, or such compensation received, by the covered service provider, an affiliate, or a subcontractor.
    - The term "direct compensation" means compensation received from any source other than the covered plan, the plan sponsor, the covered service provider, or an affiliate.

- Plan fiduciaries need to keep in mind their obligation to report noncompliant brokers or consultants to the Department of Labor.
- The effective date of this provision is December 27, 2021
- The full provision can be found starting at page 4,475 of the CAA PDF (last accessed 26 March 2021).

COBRA Extended Deadlines

Status:
Disaster Notice 2020-01, along with Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak, tolled certain deadlines up to one (1) year as a result of the COVID-19 pandemic. Included among these deadlines are COBRA's sixty (60)-day election period, COBRA's forty-five (45)-day grace period for initial payment, and COBRA's thirty (30)-day grace period for payments after the initial payment.

What it is:
On 1 March 2021 (the day many suspected would end the tolling period), Federal agencies issued Disaster Notice 2021-01, which instead clarified that individuals and plans with timeframes subject to the tolling period are to be disregarded until the earlier of:

1. One (1) year from the date the individual was first eligible for relief; or,
2. Sixty (60) days after the announced end of the National Emergency (the end of the Outbreak Period).

As of the date of this notice the National Emergency remains ongoing, **but in no case will COBRA deadlines be extended for more than one (1) year past the original due date.** Under current guidance, after the expiration of the extended deadlines normal deadlines and grace periods will apply, and reinstatement of coverage for periods with unpaid premiums may not be possible.

By way of examples, if a qualified beneficiary would normally be required to make a COBRA election by 1 March 2020, they now have until 28 February 2021 (i.e., one year from 1 March 2020). If a qualified beneficiary would normally be required to make a COBRA election by 1 March 2021, they now have until 1 March 2022.

What you need to know:
- **If you have unpaid premium payments that would normally have been due during the tolling period,** the end of the grace period for those premium payments will be thirty (30) days after the earlier of:

  1. one (1) year after the premium due date; or,
  2. Sixty (60) days after the announced end of the National Emergency (the end of the Outbreak Period).

If you owed premiums prior to 1 March 2020, you may have a grace period of less than thirty (30) days.

- **If you have not paid your initial COBRA premium**, the deadline for making the payment will be forty-five (45) days after the earlier of:

  1. one (1) year after the date you elected COBRA; or,
  2. Sixty (60) days after the announced end of the National Emergency (the end of the Outbreak Period).

If you elected COBRA prior to 1 March 2020, you may have a grace period of less than forty-five (45) days.

- **If you experienced a COBRA qualifying event and you have not yet elected COBRA**, the COBRA election deadline will end sixty (60) days after the earlier of:

  1. one (1) year after your coverage terminated; or,
  2. Sixty (60) days after the announced end of the National Emergency (the end of the Outbreak Period).

If your election period began before 1 March 2020, you may have less than sixty (60) days to elect COBRA.

- **If you experienced an event that requires you to notify your Plan of the event** (such as divorce, legal separation, a child turning 26, or a determination of disability or the end of disability) you must notify the plan within sixty (60) days (thirty (30) days to notify of the end of disability) after the earlier of:

  1. one (1) year after the event; or,
  2. Sixty (60) days after the announced end of the National Emergency (the end of the Outbreak Period).

If the event occurred before 1 March 2020, you may have less than sixty (60) days.

View Healthgram's update to learn more.

CMS Expanding No Cost-Sharing Requirement for Diagnostic Testing Related to COVID-19

Status:
On 26 February 2021 the Centers for Medicare & Medicaid Services (CMS) released FAQs Part 44 addressing coverage of items and services related to diagnostic testing for COVID-19 and coverage of qualifying coronavirus preventive services, including recommended COVID-19 vaccines. The people addressed in FAQs No. 44 include group health plans, health insurance issuers offering group or individual health insurance coverage, and providers of COVID-19 related services to the uninsured.

What it is:
FAQs Part 44, available at CMS.gov, provides new guidance and clarifies previous FAQ-based guidance about implementing Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act).

What you need to know:

- According to the CMS:
  - "The FFCRA prohibits plans and issuers from imposing medical management, including specific medical screening criteria, on coverage of COVID-19 diagnostic testing. Plans and issuers cannot require the presence of symptoms or a recent known or suspected exposure, or otherwise impose medical screening criteria on coverage of tests." [FAQs Part 44, A1].
  - "Plans and issuers must provide coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance), prior authorization, or other medical management requirements for COVID-19 diagnostic testing of asymptomatic individuals when the purpose of the testing is for individualized diagnosis or treatment of COVID-19." [FAQs Part 44, A2].
  - "Plans and issuers should maintain their claims processing and other information technology systems in ways that protect participants, beneficiaries, and enrollees from inappropriate cost sharing and should document any steps that they are taking to do so. The Departments will take enforcement action, where appropriate, to ensure consumers receive the protections they are entitled to under the FFCRA and CARES Act." [FAQs Part 44, A5].
  - "Section 3203 of the CARES Act and its implementing regulations require non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage to cover, without cost-sharing requirements, any qualifying coronavirus preventive services pursuant to section 2713(a) of the PHS Act and its implementing regulations (or any successor regulations). The term "qualifying coronavirus preventive service" means an item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is, with respect to the individual involved—
    - An evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); or
    - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) (regardless of whether the immunization is recommended for routine use)." [FAQs Part 44, A6].
- For more information, see FAQs Part 44, *available at* https://www.cms.gov/files/document/faqs-part-44.pdf (last accessed 26 March 2021).