COMPLIANCE News to Know

News from September 9 - 29th, 2023 V2.15

Arrow Benefits

PATRIOT GROWTH INSURANCE SERVICES COMPLIANCE

Upcoming...

October 12 - Patriot EB Webinar: *Basics of Consumer-Driven Health Plans*: Register Here: **CDHP Basics**

October 15 - Deadline to notify Medicare Part D eligibles if Rx Drug coverage is creditable. **Model Notice at CMS**

October 16 - Electronic filing deadline for the 2.5 month extension to file the Form 5500 (if an extension was filed)

December 31 - First Gag Clause Attestation filing due. Plans and Issuers **file via CMS' HIOS Portal**

Gag-Clause Attestation: Who Should File? Issuer, TPA, Plan, PBM, or All?

Gag Clause Prohibition Attestation Reminders

- The first annual **Gag Clause Prohibition Compliance Attestation** is due by group health plans (Plans) & issuers by December 31, 2023. It will be due annually thereafter.
- Submission of the form is required via the government's **HIOS portal.** The **CMS** website outlines **instructions**, FAQs, & templates.
- Verify who will file on behalf of the Plan.

Steps to Verify Plan Compliance with the Gag-Clause Attestation

1. Verify which Plans are subject to the attestation requirements.
    a. Most fully insured and self-funded/level-funded ERISA Plans are required to attest.
    b. Exceptions apply for account-based & other plans.
    c. Refer to Section 1.2 (page 3) of **CMS' Gag Clause Attestation Instructions.**

2. Employers should verify (for each Plan and its providers) who will complete the attestation on behalf of the Plan.
    a. This may be a combination of the Insurer, Plan, TPA, or PBM (for SF/LF Plans)
    b. Some TPAs & PBMs will only attest to the services they provide to the Plan. This means the Plan Sponsor (i.e., Employer) is responsible for thorough & accurate filing.

3. Once Employers verify who will submit the attestation, *document it in writing.*
    a. Secure confirmation via e-mail from each entity who will attest.
    b. Secure receipt of submission of attestation once made via HIOS.
    c. Include the procedures within compliance processes for annual submission.

Are there exceptions?

Yes. Per **CMS' Instructions Manual:**

1.2.1 Attesting on an Issuer's Behalf:
An issuer can attest on its own behalf as well as on behalf of other issuers in the same controlled group. Additionally, an issuer that contracts with a third party to enter into provider agreements on its behalf may have that third party attest on its behalf.

1.2.2 Attesting on a Plan's Behalf

A Plan may attest on its own behalf. The statute requires Plans and health insurance issuers offering group health insurance coverage (as well as individual health insurance coverage) to annually submit a GCPCA. This means **both the issuer and Plan are required to submit a GCPCA with respect to a fully-insured Plan.** However, if coverage under a Plan consists of group health insurance coverage, and the issuer of that coverage submits a GCPCA on behalf of the Plan, the Departments will consider both the Plan and issuer to have satisfied the attestation submission requirement. **Issuers can attest for fully-insured Plans, including non-Federal governmental plans and church plans.**

Note to Self-Funded & Level Funded Plans

If the Plan utilizes more than one TPA, with each administering a subset of covered Plan benefits, each TPA may attest on the Plan's behalf with respect to the subset of benefits it administers. However, if a self-funded Plan chooses to enter into such an agreement, and a TPA fails to submit the Plan's attestation to the Departments as required, the Plan violates the requirement to provide an attestation of compliance.

Departments Extend Comment Period on Mental Health Parity Proposed Rules

The Departments of the IRS, EBSA, and HHS extended the comment period to October 17th, 2023, from the original date of October 2, 2023. The Departments' proposed rules to strengthen mental health parity analyses requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA) have garnered concern from stakeholders. Given the epic fails by Plans and Issuers after the first two government-conducted audits, it's no surprise that Plans are making noise. The proposed rules would set even more requirements around how Plans should conduct NQTL analyses to ensure parity between medical/surgical and mental health benefits.

October is Cybersecurity Awareness Month!

Plans (via their Employer Plan Sponsors) must safeguard Protected Health Information (PHI) that it creates, receives, maintains, or transmits. Yes, there are a few exceptions based on Plan size, type, and level of "handling" PHI. However, Plans that offer "medical care" under ERISA, (and their Business Associates) must protect PHI and electronic PHI and implement HIPAA Privacy & Security protocols. On September 11, HHS released details of a resolution agreement with the nation's largest publicly operated Plan. The Plan must pay $1.3 million dollars and implement a comprehensive corrective action plan to conduct a thorough HIPAA risk assessment protect ePHI from vulnerabilities, including cyber-attacks. Read the **press release** and **resolution agreement** for more details.

FAQ Part 61: the Affordable Care Act (ACA) & the Transparency in Coverage (TiC) Act

This **3-page FAQ** from Federal Departments provides clarity on implementation of reporting requirements for non-grandfathered Plans and issuers offering non-grandfathered Plans and individual health insurance coverage under the TiC Rules. Departments address two questions pertaining to Rx drug Machine-readable file (MRF) guidelines and whether safe harbors are required.