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HEALTH & WELFARE PLAN LUNCH GROUP

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2022 Year in Review Agenda

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  - Surprise Billing
  - Mental Health Parity and Addiction Equity Act ("MHPAEA") analysis on Non-Quantitative Treatment Limitations ("NQTLs")
  - Miscellaneous CAA items
- Transparency in Coverage ("TiC") Reporting
- Dobbs v. Jackson Women's Health Organization (Dobbs) and Medical Travel Benefits
- Recap of Coronavirus Impact on Employer H&W Benefits
- Proposed 1557 Regulations
- COLA Updates and other Miscellaneous Items

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Washington UPDATE

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Post-Election Review

- Republicans have slim House majority (similar to what Democrats have now)
  - Not all races finally called, but looks to be 222-213
  - Can lose just 4 votes to get to the 218 needed to pass a party-line Republican bill
- Democrats to retain at least 50 Senate seats
  - Final split depends (once again) on GA runoff on Dec. 6 (early voting has already begun)
- Legislation in the 118th Congress will be difficult in a closely divided legislature
  - House will focus heavily on oversight
- The Biden Administration will focus on regulatory initiatives
- Lame duck presents opportunity for a variety of initiatives to get passed
  - The package has to be bi-partisan (60 vote threshold in the Senate)
  - Any legislation depends on willingness of D's and R's to negotiate
  - Discussions are in process, but there are not yet decisions and much is up in the air

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Lame Duck Timeline and Context

- **Driving the train: December 16:** funding for the federal government expires
  - Action required by this date to prevent a shut down
  - A short-term continuing resolution (CR) to give more time to negotiate likely (Dec. 23?)
- **Key issues** that **may** ride along with a funding package including:
  - Medicare health extenders and other health related provisions
  - Tax provisions
  - Bi-partisan retirement legislation ("Secure 2.0")
  - Debt limit (not expected to be reached until 2023, so doesn't "have" to be done in this congress

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Mental Health Matters Act (HR 7780)

- Passed House in Sept. 29, on a (mostly) partisan basis (one R vote)
  - Vote in the Education and Labor Committee was completely partisan
- Authorizes DOL to impose civil monetary penalties on plan sponsors, plan administrators, and health insurers for MHPAEA violations
- Plan participants, beneficiaries, fiduciaries and DOL can sue to require re-adjudication of claims and payment of benefits to remedy violations of title I of ERISA, notwithstanding any other available relief (not limited to health)
- Provides generally that arbitration clauses, class action waivers, and discretionary clauses regarding plan interpretation are unenforceable and impermissible (not limited to health)
- Limited exceptions for collectively bargained arrangements (arbitration clauses) and multiemployer plans (discretionary clauses)
- $275 million in funding (over 10 years) for DOL enforcement of parity provisions
- Outlook: Partisan nature of the bill makes it less likely for inclusion in any end of year package

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HR 7666: Restoring Hope for Mental Health and Well-Being Act of 2022

- Bi-partisan: Passed the House on June 22, by a vote of 402-20
- Would eliminate the ability of self-funded public plans to opt-out of the parity requirements
  - GAO reported in 2019 that there were 207 plans that had opted out
  - Generally effective 180 days after the date of enactment, with a special rule for collectively bargained plans
- Provides for funding for states that enforce the parity provisions, including the NQTL comparative analysis with respect to insurers
- Amends ERISA to provide increased transparency for plan sponsors with respect to pharmacy costs.
  - Specifically requires that plan sponsors receive reports on the costs, fees and rebates under PBM contracts.

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Ways and Means Committee Provisions

- **A package of proposals approved on a bi-partisan basis on September 21, 2022**
- Group health plan requirements:
  - "Forensic medical exams" must be covered without cost-sharing and regardless of whether the provider is in-network
  - New requirements relating to provider directories
  - Standards for the definition of mental health and substance use disorder benefits for purposes of the parity rules
  - New disclosure requirements
- Outlook?

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Ways and Means Committee - Forensic medical exams

- "Forensic medical exams" must be covered without cost-sharing and regardless of whether the provider is in-network.
- Applies surprise billing requirements to OON providers as if the services were emergency services.
- A "forensic medical exam" is: (1) an examination for physical trauma; (2) a determination of penetration or force; (3) an interview; and (4) the collection and evaluation of evidence.
- The coverage requirements do not apply if the State in which the exam was furnished is responsible for full out-of-pocket costs with respect to the exam. If a plan denies a claim on the ground that the State will pay for the exam, it must notify the individual that they may seek reimbursement from the State and, if authorized by the individual, notify the appropriate State agency of the claim.
- Effective for plan years beginning on or after Jan. 1, 2025.

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Ways and Means Committee – Provider directories

- **Information on accepting new patients**
  - Amends the provider directory requirements added by the CAA to include information provided as to whether new patients are being accepted and, if so, whether in-person or telehealth (or both) are available for new patients. This information is to be updated at least annually.
  - Providers/facilities are required to provide such information to plans and to update this information at least annually.
  - Effective for plan years beginning on or after Jan. 1, 2025.
- **Machine readable files; providing information to the federal government; posting on a public governmental website**
  - Group health plans are required to provide provider directory information annually to the federal gov't (HHS/DOL/IRS) in a machine readable file. This information will be made available on a public federal website.
  - Effective for plan years beginning on or after Jan. 1, 2025. The federal government is to make the files publicly available starting no later than July 1, 2025.

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Ways and Means Committee Provisions – Parity provisions

- **Definition of mental health and substance use disorder (MH/SUD) benefits by reference to nationally recognized standard**
  - For purposes of the parity rules, "mental health conditions" and "substance use disorder" plans must include at least the conditions that fall into any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.
  - Effective for plan years beginning on or after the date that is 6 months after the date of enactment.
- **Agency report and outreach**
  - HHS, DOL, and Treasury are required to submit a report to Congress not later than Jan. 1, 2024 regarding coverage of MH/SUD crisis services under group health plans.
  - The tri-agencies are also directed to initiate a public outreach campaign to inform individuals with insurance coverage required the federal requirements for MH/SUD crisis services.

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Ways and Means – Disclosure

- **Disclosure of percentage of in-network providers of behavioral health and substance use disorder treatment**
  - Group health plans must disclosure along with the SBC and on a public website information regarding the number and percentage of in-network providers for MH/SUD benefits in the service area of the plan.
  - HHS/DOL/Treasury are to develop a system for qualitatively reflecting the breadth of such networks (e.g., high/medium/low or a star rating) that correspond to ranges of percentages.
  - Not later than June 30, 2025, HHS/DOL/Treasury are to post on a public website a list of all MH/SUD providers in the country, the location of such providers, and provider specialty (if any). Providers/facilities are to annually provide to HHS the information needed for the posting of provider information.
  - Not later than Dec. 31, 2026, the tri-agencies are to submit a report to Congress on MH/SUD provider networks.
- **Improved access to Summary of Benefits and Coverage (SBC)**
  - Beginning not later than Jan. 1, 2024, group health plans are required to provide SBCs in machine readable format to HHS/DOL/Treasury annually. The tri-agencies are to make the SBCs available on a public federal government website.
  - Not later than Jan 1, 2024, the tri-agencies are to submit a report to Congress regarding SBCs, including recommendations for improvement.

Other issues

- Mental health parity continues to be a congressional focus on both a partisan and bi-partisan basis, other proposals may surface.
  - E.g., Senator Tina Smith (D-MN) and Finance Committee Chair Ron Wyden (D-OR) recently introduced S. 5093, the "Behavioral Health Network and Directory Improvement Act"
- HDHP/HSA telehealth benefits
  - Possible extension of the ability of HDHPs to pay for telehealth pre-deductible
- Restore Protections for Dialysis Patients Act (HR 8594/S 4750)
  - Response to SCOTUS decision in *Marietta Memorial Hospital v. DaVita Inc.*
    - Plan did not have in-network dialysis coverage and covered dialysis at 87.5% of Medicare rather than the "reasonable and customary" rate. The court held that the plan did not violate the Medicare Secondary Payer rules.
  - Would amend Medicare secondary payer requirements to require health plans to cover benefits for renal dialysis on the same basis as other medical services necessary to treat other chronic medical conditions that are covered under the plan.

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Consolidated Appropriations Act of 2021 ("CAA")

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CAA Overview

- Title I-No Surprises Act/Patient Protections-applies to grandfathered health plans but not applicable to excepted benefits and stand-alone retiree health plans except as described below)
  - Balance billing protections
  - Continuity of Care requirements
  - Provider directory requirements
  - Price comparison tools ("CAA Transparency") (Advanced EOB delayed until further guidance)
  - ID Card information
  - Primary Care designation (now applies to GF plans)
- Title II-Transparency
  - No gag clauses in service agreements
  - NQTL comparative analysis disclosure
  - Compensation disclosure for "brokerage" and "consulting" service providers (all GHPs)
  - RX reporting

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CAA—Rx Reporting

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CAA—RX Reporting

- CAA requires group health plans and health insurers to report to CMS certain information related to medical and Rx spending
  - Applicable to GHPs subject to ACA's health insurance reforms (including GF plans) other than HRAs
  - Not applicable to:
    - Excepted benefits such as dental, vision, health FSA
    - Not applicable to stand alone retiree health plans

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CAA—RX Reporting

- There is both an initial report and annual report
  - Initial report is December 27, 2022 (for 2020 and 2021 calendar year data).
  - The first annual report is due June 1, 2023 (for 2022 calendar year data) and then every June 1 thereafter (for the prior calendar year).

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CAA—RX Reporting

- Plan Sponsors of fully insured plans can rely on insurance carriers and shift responsibility/liability with a written agreement with carrier
- Plan sponsors of self-insured plans can rely on TPAs or PBMs or both to report some or all of the information on their behalf but remain responsible for reporting failures
  - Should have written agreement between the parties regarding the filing responsibilities/obligations
  - **Coordination required among plan sponsor, TPAs and PBMs**

CAA—RX Reporting

- Plan can file all plan and data files
- Plan can file some and vendor can file some
- Vendor(s) can file all files
  - Some information will still be required from the plan sponsor
  - Challenges presented when plans have multiple vendors and/or benefit package options
  - Claims administrator different from PBM
  - Plan with different benefit package options administered by different claims administrators
  - Medical benefit or PBM benefit has carve out vendors
    - Medical claims administrator different from behavioral health vendor
    - PBM and special drug PBM are different

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Practice Pointers:

- Work with plan vendors to ensure that all vendors have all the required information for the P2 file, including providing each vendor's name and EIN to the other vendors
- Confirm that each of the plan's vendors will submit a P2 file that uses a unique plan name and number for each separate benefit package option offered by a plan.
- If the plan cannot confirm that vendors use unique plan names and numbers for each benefit package option, the plan can either:
  - confirm that at least one reporting entity's P2 file identifies all of the plan's other vendors (by name and EIN), or
  - submit its own P2 file identifying all of the plan's vendors (by name and EIN), which would require an account to access CMS's Health Insurance Oversight System ("HIOS").
- If applicable, document the "extenuating circumstances" preventing vendors from working together.

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CAA—Surprise Billing

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CAA—Surprise Billing Highlights

- Effective FPY on/after January 1, 2022 -- Balance billing protections for emergency services, certain non-emergency services, and air ambulance
- Emergency services rule is broader than under the ACA
  - Applicable to grandfathered health plans
  - Applies to out of network emergency services provided in independent free-standing clinics
  - Definition of emergency services is broader
    - Some out of network post stabilization services are considered "emergency services"
    - Emergency services not conditioned on whether otherwise covered by plan
  - "Greater of three" rule for calculating allowed amount is no longer effective (see Qualifying Payment Amount slides)
- Balance Billing protections also apply to:
  - Certain services provided by out of network provider at in-network facility
  - Air ambulance services
- New Notices
  - Balance billing protection notice posted on public site
  - Balance billing protection language in EOB
- Litigation and recent developments

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CAA—Surprise Billing/FAQs Part 55

- No-Network Plans-- NSA ***is applicable*** to no-network plans for emergency services and air ambulance.
- For No-Network Plans, NSA and QPA ***are not applicable*** to non-participating provider in a participating facility since there are no participating facilities in a RBP plan.
- No Out of Network Coverage-- NSA ***is applicable*** to plans with a network but no out-of-network coverage.
- Air Ambulance--Can limit coverage to emergency only; NSA applies even if point of pick up is outside the US if air ambulance is properly licensed by a state.
- Behavioral Health Crisis Centers--Generally covered to the extent the service meets the definition of emergency services and the center is licensed under state law to provide emergency services and geographically separate from the hospital (classifies as an Independent Freestanding Emergency Department).

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CAA—Other Patient Protections (Effective FPY On/After 1/1/22)

- Continuing Care Patients may be eligible for up to a maximum of 90 days of transitional care to continue treatment under the same terms and conditions as would have applied had the termination not occurred
- Plan ID cards must include information about plan deductibles, out-of-pocket maximums, telephone number, and website address.
- Provider Directory—GHP must maintain a regularly updated database of providers and facilities on public website, and a prompt response protocol for inquiries about provider/facility network status.
  - Cost-sharing levels higher than in-network cannot be imposed if participant can prove they relied on inaccurate information from directory. Good faith interpretation while rules are pending.

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CAA—NQTL Comparative Analysis

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CAA—NQTL Analysis Overview

- Plans must perform and document a comparative analysis of Plan's design and application of the NQTLs on MH/SUD benefits.
- DOL, HHS and the IRS can each request the analysis.
  - Each Agency must request at least 20 per year.
  - May also be an ERISA 104(b)(4) document!
- State regulators (e.g. state departments of insurance) can also request.
- Agency request likely triggered by individual complaints, but Agency can request in any instance it deems "appropriate."

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The Rule

- MHPAEA requires that any NQTLs imposed by plans on MH/SUD benefits be the result of processes, strategies and evidentiary standards that are comparable to and applied no more stringently than those applied to Med/Surg in each MHPAEA benefit classification.
- Liability
  - Specific enforcement or other equitable remedy under ERISA
    - Claims reprocessing
  - $100 per day per affected beneficiary excise tax under Code Section 4980D
  - Claims by participants and beneficiaries

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The NQTL Analysis

- Provide the analysis to Agencies upon request along with the following information (5-part analysis):
  - The Plan's NQTLs and the benefits in each classification to which each NQTL applies;
  - The factors used to determine that the NQTLs will apply to MH/SUD and Med/Surg;
  - Evidentiary standards supporting the factors used to determine NQTL application and any other source or evidence relied on to design and apply the NQTLs;
  - The analysis demonstrating that the processes, strategies, evidentiary standards and other factors used to apply NQTLs to MH/SUD are comparable to and applied no more stringently than those used to apply NQTLs to med/surg;
  - The specific findings (including findings of noncompliance)
- If Agency finds the plan is non-compliant then there is a 45 day "cure period." If not cured, the plan must notify all enrolled in the plan of the non-compliance.

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The NQTL Analysis—Identifying NQTLs (non-exhaustive list)

- Medical necessity,
- Prior authorization, *
- Concurrent review, *
- Formulary design,
- Network tier design,
- Standards to participate in a network including reimbursement rates,*
- Methods for determining UCR, maximum allowable fee or similar fees structures for out of network providers, *
- Provider definitions,
- Facility definitions,
- Exclusion of specific treatments for certain conditions (such as ABA therapy),
- Step therapy,
- Any other restriction that limits the scope or duration of benefits for services provided under the plan
- * Indicates area of particular agency focus.

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The NQTL Analysis--Identifying the benefits subject to NQTL in each classification

- Inpatient/in-network;
- Inpatient/out of network;
- Outpatient/in-network;
- Outpatient/out of network;
- Emergency services;
- Prescription drugs
- Limited expansion for tiered networks and office visits

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The NQTL Analysis—Identification of factors supporting NQTLs (non-exhaustive list)

- Excessive utilization;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- Lack of adherence to quality standards;
- Claim types with high percentage of fraud;
- Current and projected demand for services;
- The analysis should explain whether any factors were given more weight than others in applying the NQTL to a benefit and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

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The NQTL Analysis—Identification of evidentiary standards, processes and strategies (non-exhaustive list)

- Internal claims analysis;
- Medical expert reviews;
- State and Federal requirements;
- National accreditation standards;
- Internal market and competitive analysis;
- Medicare physician fee schedules;
- Published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

The NQTL Analysis—Key Points

- If any of the factors, evidentiary standards, strategies, or processes are defined in a quantitative manner, the analysis must include the precise definitions used and any supporting sources for those definitions;
- The analysis should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and Med/Surg benefits and, if so, describe the process and factors used for establishing that variation;
- If the application of the NQTL turns on specific decisions in administration of the benefits, you must identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- If the analysis relies upon any experts, the analysis should include an assessment of each expert's qualifications and the extent to which the plan ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD benefits and Med/Surg benefits.
- A reasoned discussion of findings and conclusions as to the comparability of the processes with citations to sources.

January 2022 MHPAEA Report to Congress—Common Themes

- Failure to document comparative analysis before designing and applying the NQTL;
- Conclusory assertions lacking specific supporting evidence or detailed explanation;
- Lack of meaningful comparison or meaningful analysis;
  - "Many comparative analyses used a multi-page table format organized into two columns, one for medical/surgical and another for MH/SUD benefits, but then populated the table by merely reciting the same general text in both columns. The general text lacked sufficient detail to draw a meaningful comparison…"
- Non-responsive comparative analysis;
- Documents provided without adequate explanation;
- Failure to identify the specific MH/SUD and Med/Surg benefits or MHPAEA benefit classification/s affected by an NQTL.

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January 2022 MHPAEA Report to Congress—Common Themes

- Limiting scope of analysis to only a portion of the NQTL at issue;
  - "[S]everal comparative analyses for out-of-network reimbursement rates failed to identify or compare all the specific methodologies used within the relevant benefit classifications, including methodologies used by third-party pricing entities.
- Failure to identify all factors;
- Lack of sufficient detail about identified factors;
  - "[A] comparative analysis was not sufficient if it named a factor like "cost containment" or "high-cost services" in how the plan determined which benefits should be subject to preauthorization, but did not contain a precise definition of those terms, an explanation of whether and how the plan derived a numerical standard for applying such terms to benefits, and supporting documents showing the term's application.."
- Failure to demonstrate the application of identified factors in the design of an NQTL; and
- Failure to **demonstrate** compliance of an NQTL **as applied** (DOL emphasis).

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NQTL Analysis—Practice Pointers

- Carefully review the Report to Congress and the DOL's recommended compliance tools.
- Develop a practice of regularly checking for what is (and is not) a compliant NQTL, as this is a constantly developing area of MHPAEA compliance
- Carefully review your plan's NQTL analysis to ensure it includes statutorily required elements.
- For self-insured plans, consult legal counsel to amend your agreement with your TPA to ensure that that a proper and comprehensive NQTL analysis is included.

Additional CAA Reminders

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Additional CAA Reminders

- FSA Amendments--CAA enabled plan sponsors to modify their FSA carryover, grace period, and election change provisions as a result of COVID. Plan amendments reflecting such changes are required by December 31, 2022.
- "Gag-rule" prohibition, plans and insurers cannot enter into agreements with providers, provider networks, TPAs, or any entity that offers access to a network of providers if it would prevent the plan or insurer from disclosing or gathering information necessary to comply with CAA.
- Fee disclosure--entities receiving $1,000 or more in total annual direct and indirect consulting and brokerage commission and fees for ERISA covered health plans (including excepted benefit health plans) disclose such fees upon contract or renewal of the services agreement on or after December 27, 2021.
  - Direct compensation--from the plan itself—i.e., plan assets.
    - Amounts paid directly by the employer/plan sponsor would not be considered plan assets
    - Participant contributions are always plan assets.
  - Indirect compensation-- amounts paid to brokers/consultants by any entity other than the plan or employer/plan sponsor (e.g., from a TPA or insurer).

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Fee Disclosure Practice Pointers

- Identify all consultants and brokers with respect to any GHP.
- Determine whether any service provider receives any direct compensation and the amount of that compensation.
- If known, determine whether the service provider receives any indirect compensation and the amount of that compensation.
- Make a demand to any covered service provider who has not provided adequate disclosure.
- Establish and document that a responsible fiduciary actually reviews the disclosures and determines that the compensation is reasonable.

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Transparency in Coverage ("TiC")

TiC

- Not applicable to GF plans, excepted benefits, HRAs, stand-alone retiree health plans
- 2 different rules:
  - Publicly available machine-readable allowed amounts file
    - Delayed until July 1, 2022
  - Cost share estimate tool
    - Plan years beginning on or after January 1, 2023 with respect to the 500 services identified by HHS (if covered by the plan)
    - Plan years beginning on or after January 1, 2024 for all covered services

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Rule #1: Machine-readable Files ("MRFs")

- A publicly available internet website that summarizes the charges considered by a plan for covered services
  - Available to anyone without fee or condition
  - Machine Readable
- 3 different files:
  - In-network rates
  - Out of Network allowed amounts
  - Fee for service RX costs (delayed)

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MRFs—Plan Responsibility

- Self funded plans may use vendors but cannot shift responsibility
  - Originally required to post a link to MRFs on a public website
  - New guidance indicates that plans with no public website may use a third party to post the link
- Fully insured plans can shift liability/responsibility with written agreement with employer

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Rule #2: Individual Cost Sharing Liability Disclosure—Format

- Self service tool
  - Searchable for In-network provider services:
    - Billing code
    - Description of services
    - Name of network provider
    - Other factors that are used by plan (location, usage, etc.)
  - Searchable for OON allowed amounts or other amounts that accurately reflect max payment amount:
    - Billing code
    - Other factors that are used by plan to make determination
  - Refine and reorder based on proximity of in-network provider and priority of estimated amounts if multiple results
- Only the 500 services/treatments listed in regulations for PYs beginning on or after January 1, 2023
- All covered services/treatments beginning PYs beginning on or after January 1, 2024

Rule #2: Individual Cost Sharing Liability Disclosure—Format

- Paper copy
  - w/in 2 business days of receiving request;
  - May impose a limit of 20 providers per request
- Per other means as agreed to by plan and participant/beneficiary
  - This likely means can't provide electronically without consent.

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TiC—Practice Pointers

- Agreements with insurers and TPAs should specifically address who is obligated to post and maintain information required by TiC.
- Self-insured plans that have contracted with a TPA or third party to post MRFs must monitor the TPA(s) to ensure compliance.
- Plans without public websites should confirm that the TPA has posted a link to the required information on a public website.
- Review (and revise, if necessary) plan procedures for authorized representatives, and ensure that disclosure to the authorized representative complies with applicable security and privacy requirements.
- Stay updated for guidance regarding deadlines for prescription drug costs.

Dobbs and Medical Travel Benefits

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Dobbs Opinion and Health Plans

Top issues for group health plans:

- How will states address abortions?
- How will such laws impact a health plan's benefits for abortion?
  - What abortion services are impacted?
  - Can plans be liable if it pays for an illegal abortion?
  - Can plans pay for abortions in other states?
- Can employer/plans pay for travel costs?
  - Are such laws preempted?
    - Exception for generally applicable criminal laws

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Dobbs and Medical Travel—Possible Arrangements

- Through health plan to those enrolled in health plan (e.g. through an integrated HRA)
  - Limiting to surgical-type services might raise MHPAEA issues
  - HDHP issues if provided before deductible
- To those eligible for health plan even if not enrolled
  - Through an EBHRA? Perhaps but subject to EBHRA limits
- To all employees?
  - Reimbursement arrangement is likely a group health plan (even if taxable)
  - Generally, not an excepted benefit so would be subject to ACA health insurance reforms (including coverage of All required preventive care services)
  - Subject to COBRA
    - Could you do through/as an EAP? Likely not because coverage must be "insignificant" even if you do, it is still subject to COBRA and other ERISA concerns.

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Dobbs and ERISA Preemption

- State laws that "relate to" ERISA plans are generally preempted
- Preemption does not apply to generally applicable criminal laws
- Banning health plans from covering abortion might be preempted, but banning providers from performing abortion would likely not be preempted
- State laws restricting PBMs may not be preempted
- Bounty hunter laws with civil but no criminal enforcement:
  - Preempted?
  - Do laws banning abortion through civil enforcement only render abortion "illegal" for purposes of the definition of qualified "medical care"?

Recent Developments

- On Nov. 23, the Georgia Supreme Court put on hold a lower court's decision to invalidate the state's abortion ban while the opinion is being appealed
- On Nov. 15, a GA superior court judge deemed Georgia's heartbeat bill (the LIFE Act), void *ab initio*, or void from the start because when it became law in 2019, it was unconstitutional.
- The state argued that decision to invalidate the LIFE Act relied on the theory that *Dobbs* was effectively, an amendment to the federal Constitution. The state rejects this theory.

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Additional Items

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COVID-19—When Will it End?

- National Health Emergency Extended on Feb 18, 2022 Until March 1, 2023 (unless ended sooner)
- Public Health Emergency extended another 90 days on October 13, 2022.
- Impact on Coverage Mandates (Public Health Emergency)
  - Covid testing (prescribed and OTC)
  - OON Covid vaccine as preventive care
- Impact of "Tolling Period" on Plan Administration(National Emergency)
  - COBRA Elections and Premiums
  - HIPAA Special enrollment
  - Claims filing and appeals
- Special HDHP relief:
  - Notice 2020-15 HDHP Relief (allows covid treatment below deductible): extended until further notice
  - Extension of Telehealth from April 1, 2022 through December 31, 2022—will it be extended again?

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COVID-19 and Telehealth

- Employers with HDHPs were allowed to provide coverage for telehealth services before the minimum HSA compatible deductible was met in 2020/2021. CAA extended relief for April 2022 - December 2022.
- Two challenges:
  - Unless relief is extended into 2023, FMV of any telehealth services applies to HDHP coverage until HDHP/HSA deductible is met (not including preventive services). COVID-19 testing/treatment would not be disqualifying (Notice 2020-15). No deadline (not geared to the PHE) but unclear whether the IRS will, at some point, withdraw this exception.
    - Is it possible to provide telehealth benefits prior to the minimum HSA compatible deductible if the telehealth program does not provide "significant benefits in the nature of medical care or treatment"?
  - HSA eligibility January through March of 2022 if pre-deductible telehealth coverage was received: HSA eligibility is determined on a month-to -month basis. Are these individuals eligible to contribute Jan-Mar 2022? Also there is what is known as the "full contribution rule" for those who are enrolled in a HDHP with no other disqualifying coverage as of December 1 of any year.

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Disaster Relief Filing Extensions

- Weather-related disasters extended several filing deadlines. Those in FEMA-designated areas with a valid extension to file their 2021 Form 5500 due to run out on October 17, 2022, will now have until February 15, 2023:
  - IR-2022-173: Hurricane Ian/South and North Carolina: Sept 25/28 (respectively), 2022-Feb 15, 2023
  - IR 2022-168: Hurricane Ian/Florida: Sept 23, 2022-Feb 15, 2023
  - IR 2022-164: Storms and Flooding/Alaska: Sept 15, 2022-Feb 15, 2023
  - IR 2022-161: Hurricane Fiona/Puerto Rico: Sept 17, 2022-Feb 15, 2023
  - MS-2022-01: Mississippi Water Crisis victims: Aug 30, 2022-Feb 15, 2023
- The IRS automatically provides filing and penalty relief to any taxpayer with an IRS address of record located in the disaster area. Visit https://www.irs.gov/newsroom/tax-relief-in-disaster-situations for more information.

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Proposed 1557 Regulations

- Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability under any health program or activity that is receiving federal financial assistance on the grounds that such discrimination is prohibited under existing federal laws.
- Final regs have twice been issued—first in 2016, and again in 2020
- The 2022 proposed rule would re-instate several provisions from the 2016 Final Rule that had been removed or amended by the 2020 Final Rule and made a few refinements (e.g., taglines, notices, and grievance procedures).

Telephone Consumer Protection Act of 1991 (TCPA)

- The TCPA generally restricts certain unauthorized automated calls and texts to residential and cellular phones, including some restrictions potentially applicable to health care messages.
- *Fiorarancio v. Wellcare Health Plans, Inc.* opinion reminds plan sponsors that even if a plan is in compliance with all other applicable laws, including HIPAA privacy requirements, the plan must still be cognizant of the TCPA when reaching out to plan participants via texts and pre-recorded messages, absent express consent.
- Plan sponsors should evaluate the administrative practices of their TPAs and vendors and have clear language in service agreements with regard to which party has the responsibility to obtain proper consent (and the liability for such failures).

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Additional Items

- Family Glitch: IRS now provides separate affordability determinations for employees and for family members. No changes to ACA employer mandate (play or pay) under Section 4980H of the IRC. Play or pay penalty only triggered if the offer of self-only coverage to employee is not affordable.
- COBRA class actions: Litigation centers around the COBRA notice. COBRA administrators/plan sponsors should review COBRA notices carefully in light of this recent litigation.
- State PBM laws and ERISA preemption: Increasingly, since *Rutledge* was decided by SCOTUS in favor of Arkansas' regulation of PBM reimbursement levels, states are passing laws regulating PBMs that may affect GHPs.
- Medicare Creditable Coverage: Rx cost reductions for Medicare enrollees in the Inflation Reduction Act may impact the analysis of whether employer sponsored prescription drug coverage is creditable. Plan sponsors need to be mindful of this possibility when making this calculation.

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2023 Cost-of-living Adjustments for H&W Benefits

BENEFIT	2022	2023
HSA contribution max (including employee and employer contributions)	$3,650 ($7,300 family) (Rev. Proc. 2021-25)	3850/7750 in 2023.(Rev Proc 2022-24)
HSA additional catch-up contributions	$1,000 (this is not indexed)	Same
HDHP annual deductible minimum	$1,400 ($2,800 family) (Rev. Proc. 2021-25)	$1500 in 2023 (Rev Proc 2022-24)
Limit on HDHP OOP expenses	$7,050 ($14,100 family) (Rev. Proc. 2021-25)	$7500 ($15,000) in 2023
ACA limit on OOP expenses	$8,700 ($17,400 family)	$9,100 ($18,200 family)

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2023 Cost-of-living Adjustments for H&W Benefits (continued)

BENEFIT	2022	2023
Health FSA salary reduction max	$2,850	$3050
Health FSA carryover max	$570	$610
Limit on amounts newly available under an Excepted Benefit HRA	$1,800	$1950 in 2023
QSEHRA max reimbursement	5450 ($11,050 family)	$5850 ($11,800 family)
Transit and parking benefits	$280 (monthly)	300
401(k) employee elective deferral max	$20,500 (Catch-up contributions $6,500)	$22500 (Catch-up contributions $7,500)
Highly compensated employee	$130,000 (applies for 2022 plan year under look-back rule)	$135,000 (applies for 2023 plan year under look-back rule)
Key employee	$185,000	$200,000

PCORI Fee Filing and Payment Deadlines for 2023

PCORI Fees: For plan years ending on or after October 1, 2022 and before October 1, 2023, the updated PCORI fee amount is $3.00 x the average number of covered lives under the plan, up from $2.79. (IRS Notice 2022-59)

Plan Year End Date	PCORI Fee Rate	Filing and Payment Date
January 2022-September 2022	$2.79/covered life	July 31, 2023
October 2022-December 2022	$3.00/covered life	July 31, 2023

Questions