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HEALTH & WELFARE PLAN LUNCH GROUP

November 7, 2023

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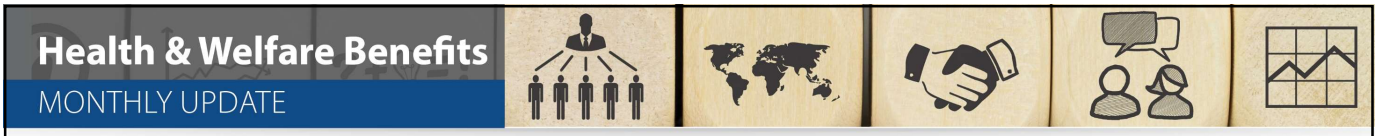

November 2023 Agenda

- Washington Update
- MHPAEA Drill Down
- Account Based Plan Issues
- Health & Welfare Updates

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WASHINGTON UPDATE

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General Legislative Environment

- Mike Johnson (R-LA) elected Speaker of the House on Oct. 25, following the ouster of former Speaker Kevin McCarthy (R-CA)
  - Major focus (as outlined in a letter from the new Speaker to House Republicans) is completing the appropriations process for the current fiscal year (FY 2024). Process could continue into next year.
- Current government stop-gap funding expires on November 17
- Israel-Hamas war creates new crisis

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Health Care Legislation

- PBM Legislation
- HSA Legislation
- Other

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PBM Legislation -- House

- Education & the Workforce
  - H.R. 4507 - Transparency in Coverage Act of 2023 (reported favorably by a vote of 38-1 on July 12, 2023)
  - H.R. 4508 - *Hidden Fee Disclosure Act of 2023* (reported favorably by a vote of 38-1 on July 12, 2023)
- Energy & Commerce
  - H.R. 3561 - *Promoting Access to Treatments and Increasing Extremely Needed Transparency (PATIENT) Act of 2023* (reported favorably by a vote of 49-0 on May 24, 2023)
  - H.R. 3285 - *Fairness for Patient Medications Act* (reported favorably by voice vote on May 17, 2023)
- Ways & Means
  - H.R. 4822 - *Health Care Price Transparency Act of 2023* (reported favorably by a vote of 25-16 on July 26, 2023)

★ House Committees on Education & the Workforce, Energy & Commerce, and Ways & Means
  - HR 5378, Lower Costs, More Transparency Act (introduced September 8, 2023)
  - Combines the work of the three committees

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PBM Legislation – Senate

- Senate HELP Committee
  - S. 1339 - Pharmacy Benefit Manager Reform Act (reported favorably by a vote of 18-3 on May 11, 2023)
- Senate Finance Committee
  - Modernizing and Ensuring PBM Accountability Act (reported favorably by a vote of 26-1 on July 26, 2023)
  - Addresses Medicare Part D only
  - The Committee is having a further markup on Nov. 8 on Medicare/Medicaid issues, including additional provisions regarding Part D (e.g., Part D sponsors must contract with any willing pharmacy that meets the plan's standard contract terms and conditions)
- Senate Commerce Committee
  - S 127, Pharmacy Benefit Manager Transparency Act of 2023 (approved by the Committee on a bi-partisan basis on March 22, 2023)
  - No new requirements for group health plans; targeted directly at PBMs, but could impact group health plans

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PBM Legislation - Key Topics*

- PBM transparency
  - PBMs are required to report detailed information to plan sponsors
  - Contracts between plans and PBMs cannot limit disclosure of information necessary to make the reports
- PBM compensation disclosure
  - Amends the ERISA compensation disclosure provisions added by CAA 2021 to clarify the PBM compensation that must be disclosed to plan fiduciaries
- Prohibition on gag clauses that would prevent pharmacists from communicating lower cost drug options to patients
- Disclosure of common ownership information to plan sponsors
- Cost-sharing restrictions for "highly rebated drugs"
- Rebate pass through
- Prohibition on PBM spread pricing
- Amendments to health coverage transparency requirements (for plans)
- Hospital pricing transparency
- Changes to current gag clause attestation requirements
- Preemption
- Possible other issues may emerge (e.g., mail order, lower co-payments for using preferred pharmacies)

*The specifics of each bill vary.

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HSA Bills Approved By Ways and Means

- Telehealth Expansion Act of 2023, HR 1843
  - Would permanently extend the ability of HSA compatible HDHPs to pay for telehealth and other remote services before the deductible is met
  - The current temporary provision expires for plan years beginning after Dec. 31, 2024
  - Approved by House Ways & Means Committee on June 7, 2023, by a vote of 30-12 (with 5 Democrats voting in favor)
  - The bill is estimated to lose $5 billion over the 10-year budget window
  - Companion Senate bill is S. 1001
- Chronic Disease Flexible Coverage Act, HR 3800
  - Would codify the IRS guidance regarding preventive services in Notice 2019-45
  - The Notice expanded the list of permitted preventive services to include certain treatments for chronic conditions
  - Approved by House Ways and Means Committee on June 7, 2023 (by a vote of 34-6)
  - Estimated to have a minimum impact on federal revenues

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HSA Bills Approved By Ways and Means

On September 28th the Ways and Means Committee approved two HSA improvement measures

- The Bipartisan HSA Improvement Act (HR 5688) would allow:
  - Limited direct primary care ($150/month)
  - Spouse only FSA (will require that FSAs be able to differentiate spouse expenses)
  - Limited employer clinics (but employer clinic services somewhat limited)
  - FSA/HRA to HSA rollover provision similar to expired provision (would clarify that FSA/HRA conversion to limited purpose FSA/HRA in connection with HSA establishment will preserve HSA eligibility)
- The HSA Act (HR 5687) would:
  - Allow HSA for those with VA coverage
  - Allow HSA for those with only Medicare Part A, but disallows other medical insurance as permitted HSA expense for post-65 individuals while in Medicare and HSA
  - Allow HSA for those with Native American Health coverage
  - Allow HSA for those in bronze and catastrophic plan coverage
  - Allow for $500 mental health services below HDHP deductible
  - Address "establishment date issue by allowing 60 days to open HSA
  - Allow age 55 catchup for both spouses
  - Increase HSA contribution to deductible and OOP exposure (up to 7500 individual, 15k family);
  - Address use of HSA distribution for LTC expenses

Other legislation

- Cap on insulin cost-sharing
  - Extend Medicare Part D $35 limit on cost-sharing for insulin to the commercial market
  - For example:
    - Affordable Insulin Now Act of 2023, S. 954, introduced by Raphael Warnock (D-GA)(bi-partisan)
    - Affordable Insulin Now Act, HR 1488, introduced by Angie Craig (D-MN)
- Telehealth Benefit Expansion for Workers Act of 2023, HR 824
  - Would make the provision of telehealth services an excepted benefit (i.e., exempt from ACA and other federal health coverage mandates), provided certain requirements are satisfied
  - In general, the bill is intended to reflect/build on COVID-era enforcement relief provided by the tri-agencies in ACA FAQs part 43 which applies to large employers providing telehealth services to employees not eligible for the employer's major medical plan, subject to certain restrictions
  - There are now different versions of the bill
    - The House Education and Workforce and Energy and Commerce Committees have marked up the bill, with differing results
- Extend Medicare Part D inflation rebates to commercial market
  - Inflation Reduction Act provides that HHS will negotiate prices for certain prescription drugs, and that drug manufacturers must pay a rebate to the federal government if drug price increases exceed inflation
  - Both these provisions apply only to Medicare Part D
  - Lower Drug Costs for Families Act, S. 1139, introduced by Catherine Cortez Masto (D-NV) would take into account commercial sector drug sales in calculating inflation rebates

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Regulations status update

- **Newly proposed rules with open comment period**
  - DOL proposed **fiduciary rule** released Oct. 31, 2023; published in the Federal Register on Nov. 3, 2023. Comments due Jan. 2, 2024.
    - Proposed changes to certain PTEs also released for comment at the same time.
  - Tri-agency proposed rules on the **IDR process** under the No Surprises Act published in the Federal Register on Nov. 3, 2023. Comments due Jan. 2, 2024.
- **Rules currently under review by OMB**
  - DOL **employee v. independent contractor** classification under the FLSA, final rule under review by OMB since Sept. 28, 2023
  - DOL **Association Health Plan** proposed rule under review at OMB since Sept. 8, 2023
  - HHS **Notice of Benefit and Payment Parameters** for 2025, proposed rule under OMB review since Aug. 24, 2023
- **Rules for which comment period has ended (awaiting further action)**
  - **MHPAEA** proposed rules (comment period ended October 17, 2023)
  - Proposed rules on **STLDI**; **Independent, Non-Coordinated Excepted Benefits; Level-Funded Arrangements; Tax Treatment of Certain Accident and Health Benefits** (comment period ended Sept. 11, 2023)
  - HHS Office of Civil Rights (OCR) proposed rule on the **HIPAA Privacy Rule and Reproductive Health** Care (comment period ended June 16, 2023)
  - **Section 1557** proposed rule (comment period closed in October **2022**)

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MHPAEA DRILL DOWN

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MHPAEA Proposed Regulations and Other Guidance

On July 25, 2023, the following information was released:

- 2023 Proposed Rules for Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA) (published in Federal Register on August 3, 2023)
- Technical Release
- 2023 Report to Congress
- Enforcement Fact Sheet
- MHPAEA Guidance Compendium

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NQTLs: Limitations Which Otherwise Limit the Scope or Duration of Benefits or Coverage

Non-Exclusive List

- Medical management standards:
  - Prior authorization
  - Concurrent review
  - Medical necessity or medical appropriateness
  - Experimental or investigative
- Formulary design for prescription drugs
- Network tier design
- Standards related to network composition
  - Standards for provider and facility admission to participate in a network or for continued network participation
  - Methods for determining reimbursement rates
  - Credentialing standards
  - Procedures for ensuring the network includes an adequate number of each category of provider and facility
- Methods for determining out-of-network rates, such as allowed amounts; usual, customary, and reasonable charges
- Fail-first policies or step therapy protocols
- Exclusions based on failure to complete a course of treatment
- Restrictions based on geographic location, facility type, provider or specialty

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NQTLs: Six Classifications

- Classifications:
  - Inpatient, in-network
  - Inpatient, out-of-network
  - Outpatient, in-network
  - Outpatient, out-of-network
  - Emergency care
  - Prescription drugs
- Permitted out-patient subclassification for office visits and permitted in-patient subclassifications for network tiers.
- No other permitted classifications or subclassifications
- Telehealth/virtual is not a permitted classification

Proposed Rule Overview: Three Basic Requirements

- "No more restrictive"
  - An NQTL that applies to MH/SUD benefits can be no more restrictive than the predominant NQTL that applies to substantially all (2/3) Med/Surg benefits within the same MHPAEA benefit classification. "Predominant" means "most common or frequent" rather than more than one-half.
- Design & application
  - The processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH/SUD benefits must be comparable to, and applied no more stringently than, those used in designing and applying the NQTL to Med/Surg benefits within the same classification.
- Outcomes Data
  - Collect and evaluate relevant data in a manner reasonably designed to assess the impact of NQTLs on access to MH/SUD benefits and Med/Surg benefits. A "material difference" in outcomes represents a "strong indicator" of a NQTL violation generally and establishes an *actual* violation for network composition specifically.

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Substantially All/Predominant Applied to NQTLs

- 2013 Final Rule:
  - For QTLS, "substantially all" means 2/3 and "predominant" means more than 1/2.
  - For NQTLs, the rule is "comparative to/applied no more stringently than," with allowance for "recognized clinically appropriate standards of care".
  - 2013 Final Rule allowed comparable NQTLs to be applied, even if an NQTL was applied to more MH/SUD benefits than Med/Surg benefits.
- NQTLs under 2023 Proposed Rule:
  - "Substantially all" means 2/3 and "predominant" means "most common or frequent variation" of the Med/Surg form of the NQTL.
  - 2023 Proposed Rule prohibits an NQTL applied to MH/SUD if it doesn't apply to 2/3 Med/Surg in same classification AND is the predominant NQTL for Med/Surg in the classification.

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Substantially All/Predominant Applied to NQTLs

- Substantially all and predominant determined based on plan payments.
  - Similar to QTLs
  - Substantially all: The portion of plan payments for Med/Surg benefits subject to the NQTL based on the dollar amount of all plan payments for Med/Surg benefits in the classification expected to be paid for the plan year.
  - Same analysis to determine the "most frequent" variation for predominant.
  - Any reasonable method can be used but must be based on plan level data ***unless*** a qualified healthcare actuary makes a determination that plan level data is not credible.
  - Questions on whether there are systems to track this data.
  - Example—Med/Surg has concurrent review on all in-patient out-of network benefits with review occurring at varying intervals of 1, 3, 5 and 7 days.
    - Since concurrent review applies to all benefits in the classification substantially all is satisfied.
    - But are there systems in place to track plan payments on the subject to each variation (1, 3,5 and 7 days)?

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Substantially All/Predominant Applied to NQTLs

- Likely would affect pre-authorization for MH/SUD intensive outpatient and partial hospitalization.
  - Treated as an out-patient benefits.
  - Very few plans would have a pre-authorization requirement for two thirds of Med/Surg out-patient benefits.
- May have affect concurrent review for in-patient benefits.
  - Often in-patient Med/Surg is reimbursed regardless of length of stay based on diagnosis related groups (DRGs) so concurrent review is not necessary.
  - Only a small number of DRGs for MH/SUD.
  - To the extent that this methodology applies to more than 1/3 of Med/Surg benefits (so the 2/3 requirement could not be met) then concurrent review could be prohibited on MH/SUD benefits.

Example: Prior Authorization

Facts

- Plan requires prior authorization for all inpatient, in-network Med/Surg and for all inpatient, in-network MH/SUD.
- Inpatient, in-network Med/Surg is approved for periods of 1, 3, and 7 days ("variations"), with 7 days as the most common (*i.e., "predominant"*).
- For Inpatient, in-network MH/SUD, 1 day is the most common (*i.e., "predominant"*) routine approval.
- The difference is not due to independent professional medical or clinical standards or fraud/waste/abuse prevention.

Conclusion

- Meets the "substantially all" test because NQTL applies to all Med/Surg in the classification.
- Fails the "predominant" test because 7 days, not 1 day, is the most common variation of the NQTL applied to Med/Surg, while the more restrictive 1-day variation applies to MH/SUD.
- In operation, the NQTL variation imposed on MH/SUD is more restrictive than the predominant NQTL variation applied to substantially all Med/Surg in classification, and the difference is not based in independent professional medical or clinical standards or fraud/waste/abuse prevention.

Query: when does a variation in a NQTL become so significant that it is actually a separate NQTL? The Proposed Rule does not address this.

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Example: Concurrent Review

Facts

- Plan requires concurrent review for all inpatient in-network facility stays (both MH/SUD and Med/Surg).
- First level concurrent review applies to all stays; escalated to 2nd level if medical necessity determination cannot be made.
- Written process requires only deny/approve from 2nd level reviewer, but in operation plan conducts a peer-to-peer review(a "variation" of the NQTL) for MH/SUD benefits while not requiring a peer-to-peer for Med/Surg.
- The difference is not due to independent professional medical or clinical standards or fraud/waste/abuse prevention.

Conclusion

- Meets the "substantially all" test because NQTL applies to all Med/Surg in the classification.
- Fails the "predominant" test because non-applicable of peer-to-peer review at 2nd level is the is the most common/frequent variation of the NQTL applied to Med/Surg and is not applied to MH/SUD. Compelling the "additional action" of peer-to-peer review to MH/SUD is a more restrictive application of the NQTL.
- In operation, the NQTL variation imposed on MH/SUD is more restrictive than the predominant NQTL variation applied to substantially all Med/Surg in classification, and the difference is not based in independent professional medical or clinical standards or fraud/waste/abuse prevention.

Example: Medical Necessity

Facts

- Plan applies a medical necessity requirement in adjudicating claims for all outpatient in-network benefits (both MH/SUD and Med/Surg).
- Plan's medical necessity requirement for ABA therapy for autism spectrum disorder (ASD) requires that primary caregivers actively participate in the ABA sessions.
- Requirement deviates from independent professional medical or clinical standards.
- No similar requirement for Med/Surg benefits.

Conclusion

- ASD is a mental health condition.
- Meets the "substantially all" test because medical necessity NQTL applies to all Med/Surg in the classification.
- Fails the "predominant" test because the most frequent variation of medical necessity review for Med/Surg does not involve primary caregiver participation.

Query: Is the active participation requirement a NQTL or a variation of a NQTL?

*Query: What would be the outcome if the active participation requirement **was** part of an independent professional medical or clinical standard? And, how do you define such a standard?*

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MHPAEA Litigation: Use of Different Guidelines

- In many instances, especially where there is a behavioral carve-out, different treatment guidelines will be used for MH/SUD benefits and Med/Surg benefits.
- This complicates the NQTL analysis because the guidelines will not have the same wording.
- Two recent cases have found differing guidelines on their own not to be the basis of a NQTL violation.
  - *Colin D. v. Morgan Stanley Med. Plan*, 2023 U.S. Dist. LEXIS 186787 (S.D.N.Y. Sep. 30, 2023)
  - *L.D. v. UnitedHealthcare Ins.,* 2023 U.S. Dist. LEXIS 132717 (D. Utah July 28, 2023).

MHPAEA Litigation: Use of Different Guidelines

- In both cases the plans used Optum Guidelines for MH/SUD and MCG Guidelines for Med/Surg.
- No parity violation because:
  - Guidelines interpreted the same base language of the plan.
  - Guidelines developed using the same processes and principles based on clinical evidence and medical expertise.
  - The Optum guidelines were not materially more stringent.
- Courts will analyze differing guidelines to see if there are material differences, but the MH/SUD guidelines only need to be comparable (and no more stringent) than the Med/Surg guidelines. They need not be identical.

ACCOUNT BASED PLAN ISSUES

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Substantiation/Pay and Chase

- Must implement a pay and chase procedure for claims not auto –substantiated
  - No prescribed time lines for completing pay and chase
- Step 1-ask for substantiation
- Step 2-if not provided TURN CARD OFF.
- Step 3-Demand repayment, offset against good claims, withhold from pay (where permitted)
  - IRS (through CCM) indicates these must occur during same plan year as unsubstantiated
- Step 4: if Step 3 not successful, then employer must treat as any other bad debt
  - Sue/send to collections
  - Forgive
    - This results in taxable income in the year in which it is forgiven

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Other FSA Issues

- Uncashed reimbursement checks
  - DOL considers these to be plan assets
    - Need to establish a "missing participant" process
  - May be subject to unclaimed property/escheat rules (if not preempted by ERISA)
- TPA licensing
  - What states require licensing for FSA/HRA administration only
  - What states? Where clients are or where participants live?

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HSA Issues

- Preventive Care
  - What exactly is preventive care?
- Last month rule:
  - If an eligible individual on first day of December, you are treated as an eligible individual for *contributions purposes* for the entire year
    - Not applicable to expenses incurred before you actually became an eligible individual
    - Must remain an eligible individual throughout the entire subsequent year or contributions allocable to months you weren't actually an eligible individual are included in income and subject to "bad withdrawal" excise tax.

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HSA Issues

- ***HIV and Hepatitis Policy Inst. et al. v. U.S. Dep't of Health and Hum. Svcs.*, No. 22-2604, 2023 WL 6388932 (D.D.C. Sept. 29, 2023).**
  - Court invalidated the 2021 HHS regulation because it concluded that the treatment of Rx coupons conflicts with the statutory definition of "cost sharing" under the ACA
  - Initial HHS MOOP required inclusion of coupons in MOOP unless generic equivalent available
  - 2021 regulation revised to allow plans to include coupon or not
  - Maybe potentially possible to accommodate by excluding from deductible, but counting in MOOP (but plans do not/cannot do this)
  - What next?
    - Which rule applies now?
    - Will HHS appeal or change regs again?
    - Will IRS address issue?
- **DOL Proposed Investment Fiduciary Rule**
  - Clearly applicable to HSAs
  - Reinstitutes Broad Investment fiduciary definition and Best Interest (PTE) Requirement for certain investment fiduciaries
    - PTE 2020-2 requirements
      - Best interest, reasonable compensation, no misleading statements, policies and procedures
    - May only apply to broker/dealers, financial institutions, and insurers
      - Applicable to NBTs?
  - HSA service providers should review all areas where they may be deemed a fiduciary under broad rule
    - E.g., "pure" robo advice

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HEALTH & WELFARE DEVELOPMENTS

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Transparency in Coverage ("TiC") Background

- Not applicable to grandfathered plans, excepted benefits, HRAs, stand-alone retiree health plans
- 2 different rules:
  - Publicly available machine-readable allowed amounts file
  - 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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TIC 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 is now effective via FAQs Part 61**

FAQs Part 61

- Rescinded compliance deferral for Rx costs MRFs.
  - Departments will issue technical requirements and implementation timeline in future guidance.
- Also rescinded blanket enforcement safe harbor of TiC Final Rules' disclosure of certain rates as dollar amounts.
  - Enforcement discretion exercised on a case-by-case basis.
    - Fact-specific determination.
    - Must demonstrate compliance with relevant provisions of TiC Final Rules would have been extremely difficult or impossible.

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
  - Subsequent guidance indicates that plans with no public website may use a third party to post the link
    - How will this rule work for Rx costs? If different medical and Rx vendors – multiple locations possible?
- Fully insured plans can shift liability/responsibility with written agreement with employer

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Practice Pointers

- Document how the plan will comply once the updated guidance regarding technical implementation is released.
- Identify the resources that will be required based on the TiC requirements for medical claims.
- Evaluate agreements with insurers/TPAs/PBMs to address who is obligated to post and maintain Rx information required by TiC.
- Self-insured plans that have contracted with a TPA/PBM or third party to post MRFs must monitor the TPAs/PBMs to ensure compliance.

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Gag Clauses—Annual Attestations

- Reminder - annual attestations of compliance.
- System for submitting attestations now open.
- First attestation covering the period December 27, 2020, to the date of the attestation is due December 31, 2023.
- Who must submit?
  - Health insurance issuers offering group health insurance coverage;
  - Health insurance issuers offering individual health insurance coverage, including student health insurance coverage and individual health insurance coverage issued through an association; and
  - Fully-insured and self-insured group health plans, including ERISA plans, non-Federal governmental plans, and church plans subject to the Internal Revenue Code.
    - Includes grandfathered and grandmothered plans.

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Gag Clauses—Annual Attestations

- Who doesn't have to submit.
  - Plans/insurers offering only excepted benefits.
  - Certain governmental benefits/plans (Medicare, Medicaid, CHIP, TRICARE, Indian Health service).
  - No enforcement against HRAs.
- Self-funded plans can enter into an agreement with service providers (TPAs, ASOs, PBMs) to submit on their behalf but the responsibility/liability remains with the plan.
- Insurer/ASO can submit on behalf of itself, fully insured group health plan, and self-insured group health plans but must coordinate with the plans to prevent duplication.
  - For fully insured, both plan and insurer have an obligation but submission by the insurer on behalf of the plan will satisfy both.

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Gag Clauses—Mechanics

- Visit https://hios.cms.gov/HIOS-GCPCA-UI to submit the attestation.
- Visit https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance to to review instructions, a user manual, as well as an Excel template for providing information required as part of the attestation.
- Attestation language is set as part of the process and displays without opportunity to modify. Attests that the plan or issuer "will not enter into an agreement, and has not, subsequent to December 27, 2020, entered into an agreement…" that violates the gag clause prohibition.
- Appears to only apply to agreements subsequent to December 27, 2020 with no affirmative requirement to amend prior agreements. But gag clause compliance necessary for any agreement after December 27, 2020, or likely any agreement renewed or amended after that date.

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No Surprises Act (NSA) Proposed Regulations for Federal IDR

The Departments published proposed regulations on November 3 with a 60-day comment period addressing the following areas:

- Communications between providers, payers, and certified IDR entities:
  - Requires plans or issuers to use claims adjustment reason codes and remittance advice codes
  - Payers must include with the QPA a statement notifying the provider of a 30-business day period for open negotiation
- Allows a 30-business day open negotiation period before federal IDR process
- Requires an IDR initiation and response notice
- Establishes an overflow eligibility review system by HHS when the dispute volume is high
- Proposes additional ways to collect fees directly from parties
- Allows more flexibility for batching
- Creates an IDR Payor Registry for plans and issuers subject to the federal IDR process. Registry required for:
  - Each group health plan subject to the IDR process
  - Issuers of individual and group policies
  - Federal Employees Health Benefits (FEHB) Program carriers

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Piedmont Healthcare, Inc. Class Action over Tracking Technologies

- Piedmont Healthcare, Inc. is facing a class action lawsuit over its use of embedded tracking technologies from Meta Platforms, Inc. on its patient facing website
- Complaint alleges that the tracking technologies allowed Meta to have access to non-public PII and PHI such as the type and date of medical appointments, the name of the provider, medical conditions, and treatment without notifying individuals that their information would be shared in violation of HIPAA and various other state laws.
- Complaint sites the following FTC and HHS letter to hospitals and telehealth providers warning of the use to tracking technologies: https://www.ftc.gov/news-events/news/press-releases/2023/07/ftc-hhs-warn-hospital-systems-telehealth-providers-about-privacy-security-risks-online-tracking
- **Practice Pointer:** HIPAA covered plan sponsors should monitor vendors' use of embedded tracking technologies as directed by HHS in this guidance from 2022: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-online-tracking/index.html

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DOL and Emblem Health, Inc. Settlement Agreement

DOL entered into a settlement agreement with Emblem Health, Inc. ("Emblem") on September 29, 2023, regarding Emblem's practice of out-of-network (OON) cross-plan offsetting.

- Emblem is an insurer and third-party administrator of self-funded group health plans.
- Cross-plan offsetting is a method used by insurers and third-party administrators to recover overpayments paid to a provider by reducing or eliminating payments to that same provider for another patient's claim covered under another health plan, that can be either self-funded or fully insured.

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Settlement Agreement

- DOL's settlement with Emblem consisted of four parts:
  - settlement agreement,
  - letter to participants and beneficiaries,
  - notice to be posted on Emblem's website, and
  - consent order, which will only be filed with a court if Emblem breaches the settlement agreement.
- The DOL press release on the settlement can be found here. https://www.dol.gov/newsroom/releases/ebsa/ebsa20231005.

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Emblem's Obligations

- The settlement agreement required Emblem to:
  - Cease cross-plan offsetting.
  - Remove cross-plan offsetting language from its policies procedures and practices no later than January 1, 2024 (or for insured plans after any state required approval).
  - Send a letter with an attached claim form to any participant affected by a cross-plan offset of $50 or more from July 16, 2015 to September 29, 2023, and via e-mail where e-mail address on file:
    - informing them that if they were balance billed, they should contact Emblem, and
    - that they will be entitled to reimbursement of the cross-plan offset amount.
  - Post a notice on Emblem's web portal with similar content to the letter.
- Emblem may take reasonable steps and seek corroborating documentation that the participant was balance billed.

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Consent Order

- As mentioned earlier, the consent order attached to the settlement agreement would only be filed with a court if Emblem breaches the settlement agreement.
- Consent order alleges fiduciary breaches based on ERISA's exclusive benefit requirement, prudence requirement, and requirement to act in accordance with plan documents.
- Consent order further alleges prohibited transactions under three subsections of ERISA and a violation of ERISA's requirement for reasonable claims and appeals procedures.
- If the consent order were filed, Emblem does not admit to those allegations but agrees "not to submit any filing" denying the allegations.

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PCORI Fee Filing and Payment Deadlines for 2024

PCORI Fees: For plan years ending on or after October 1, 2023 and before October 1, 2024, the updated PCORI fee amount is $3.22 x the average number of covered lives under the plan, up from $3.00. (IRS Notice 2023-70)

Plan Year End Date	PCORI Fee Rate	Filing and Payment Date
January 2023-September 2023	$3.00/covered life	July 31, 2024
October 2023-December 2023	$3.22/covered life	July 31, 2024

Health & Welfare Benefits
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2024 Cost-of-living Adjustments for H&W Benefits

BENEFIT	2024	2023
HSA contribution max (including employee and employer contributions)	$4,150/$8,300 Rev. Proc. 2023-23	$3,850/$7,750 in 2023
HSA additional catch-up contributions	$1,000	$1,000
HDHP annual deductible minimum	$1,600 ($3,200 family)	$1,500 in 2023
Limit on HDHP OOP expenses	$8,050 ($16,100 family)	$7,500 ($15,000 family)
ACA limit on OOP expenses	$9,450 ($18,900 family)	$9,100 ($18,200 family)
Limit on amounts newly available under an Excepted Benefit HRA	$2,100	$1,950

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2024 Cost-of-living Adjustments for H&W Benefits

BENEFIT	2024	2023
Health FSA salary reduction max	TBD	$3,050
Health FSA carryover max	TBD	$610
QSEHRA max reimbursement	TBD	$5,850 ($11,800 family)
Transit and parking benefits	TBD	$300 (monthly)
401(k) employee elective deferral max	$23,000 (Catch-up contributions $7,500)	$22,500 (Catch-up contributions $7,500)
Highly compensated employee	$155,000 ($150,000 applies for 2024 plan year under look-back rule)	$150,000 ($135,000 applies for 2023 plan year under look-back rule)
Key employee	$220,000	$215,000

Questions