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HEALTH & WELFARE PLAN LUNCH GROUP

February 2, 2023

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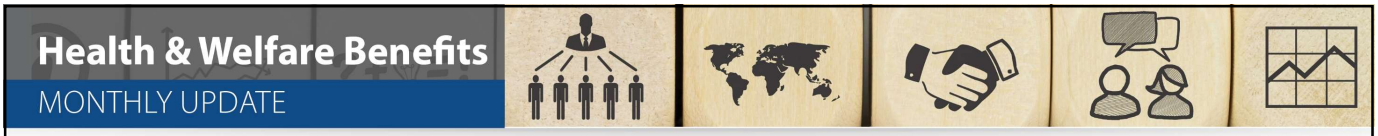

February 2023 Agenda

- Year-End Legislative Update, HSA Extension and COVID Mandate Status
- Preventive Services/ACA
- Section 1557 Regulations—Brief Review and Sample of Cases
- HIPAA Update—Online Tracking
- MHPAEA
- IDR Developments
- Miscellaneous Items—Disaster Relief and DOL 2023 Penalty Increases

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Health & Welfare Benefits
MONTHLY UPDATE

Year-End Legislative Update

- CAA 2023
  - Impact on HSAs
  - Impact on MHPAEA (discussed later)

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CAA 2023 HSA Extension

- Background and Recap
  - HSA eligibility generally prohibits coverage below the deductible *except for*
    - Preventive care
    - Permitted insurance (e.g., vision, dental, certain fixed indemnity)
    - Certain limited benefits that do not provide significant benefits in nature of health care
      - EAP, wellness, disease management
  - COVID exceptions
    - CAREs Act allowed for telehealth and other remote care for plan years commencing prior to 12/31/2021
      - Extended for 2022 for "months starting after March 31, 2022 and before December 31, 2022"
    - Separately,
      - Notice 2020-15 HDHP Relief (allows COVID treatment below deductible): extended until further notice
      - COVID vaccines and testing required to be covered

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CAA 2023 HSA Extension

- The telehealth exception was further extended (with another gap, this time for certain non-calendar year plans) "for plan years beginning . . . after December 31, 2022 and before January 1, 2025."
- This caused a gap for non-CY plans (next slide) . . . but, apparently non-calendar year plans may take advantage of the exception for their full 2023 FY

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CAA 2023 HSA Extension

- Potential Gaps in Extension(s)
  - Calendar year plans with disqualifying coverage in January- March 31, 2022
  - FY Plans with disqualifying coverage for any "stub period"
    - Coverage for FY plans with plan year commencing between January 1, 2022 and March 31, 2022
    - Coverage in 2023 before commencement of new 2023 PY
- Potential Impact
  - Loss of eligibility for periods in which disqualifying coverage available on first of month
  - Potential individual (and even employer withholding) tax implications
  - (Partial) Solutions?
    - Last month rule (December 1st) mitigation and limitations
    - Pay FMV for telehealth during gap
    - No telehealth/remote care on first of month?

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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, until April 11, 2023.
- But wait . . .apparently the emergencies will end on May 11th

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COVID-19—When Will it End?

- Impact on Coverage Mandates (Public Health Emergency)
  - COVID testing (prescribed and OTC) not required (but should you cover it ?)
  - OON Covid vaccine as preventive care (IN coverage is required under ACA)
  - Exception for Stand-alone telehealth/remote care for those ineligible in GHP
  - Impact on EAP ability to cover COVID testing/vaccinations
  - Collateral issues
    - Potential impact on MHPAEA testing if no longer mandated, yet cover with no cost share
    - Potential increases in cost of vaccines etc

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COVID-19—When Will it End?

- Impact of "Tolling Period" on Plan Administration (National Emergency)

  Time no longer stands still 60 days after expiration . . . consider impact on
  - COBRA Elections and Premiums
  - HIPAA Special enrollment
  - Claims filing and appeals
- Check communications, SPDs, SMMs, Notices, etc and update

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PREVENTIVE SERVICES
(What's New and Reminders)

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Braidwood Management v. Becerra

- On September 7, 2022, a federal judge in the Northern District of Texas issued a decision in *Braidwood Management v. Becerra*.
- The decision calls into question the constitutionality of some aspects of the Affordable Care Act's (ACA's) preventive services mandate.
- The ACA (for non-grandfathered plans) requires coverage of a list of preventive vaccines, screenings , drugs and other services (preventive services) without any cost sharing.
  - Currently there are 22 categories of preventive services for adults, an additional 27 for women, and 29 for children.

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Braidwood Management v. Becerra

- Preventive services have four different sources:
  - First, preventive services that receive an "A" or "B" recommendation from the U.S. Preventive Services Task Force (USPSTF) must be covered. These include colonoscopies, mammograms, cancer screenings etc.
  - Second, the Advisory Committee on Immunization Practices (ACIP) recommends certain immunizations.
  - Third, the Health Resources and Services Administration (HRSA) issues "comprehensive guidelines" with respect to infants, children, and adolescents for preventive care and screenings.
  - Fourth, HRSA issues guidelines with respect to women for "such additional preventive care and screenings" not covered above.

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Braidwood Management v. Becerra

- Court's ruling concerns those services designated by the USPSTF which is a non-governmental body of volunteers "with appropriate expertise" to make healthcare recommendations.
  - A sub-agency of the Department of Health and Human Services "convenes" the USPSTF.
  - By statute, USPSTF and its members "shall be independent and, to the extent practicable, not subject to political pressure."
- The Court ruled that the members of the USPSTF are principal "Officers of the United States" and must be appointed pursuant to the Constitution's "Appointments' Clause" which requires appointment by the President and confirmation by the Senate. So, USPSTF members were improperly appointed.
  - Unlike the USPSTF, the recommendations of ACIP and HRSA are subject to approval by the HHS secretary, who is properly appointed, So, preventive services designated by those organizations, according to the Court, are valid.

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Braidwood Management v. Becerra

- Court ordered further briefing on the remedy.
  - Briefing was apparently completed on January 27, 2023.
    - Braidwood is arguing for a "universal remedy" to set aside all USPSTF recommendations with "A" or "B" ratings that were issued on or after March 23, 2010.
    - The government is arguing that the remedy should be to strike any statutory provision that insulates the USPSTF's recommendations from review and affirmation by the HHS Secretary --therefore solving the Appointments' Clause problem.
- Very likely that that any final order will be appealed to the Fifth Circuit. Also, once there is a final district court order it might be stayed pending appeal.
- Unlikely, at this time, that any insurers or group health plan will drop coverage without cost sharing for preventive services designated by the USPSTF. But certain changes, especially for expensive preventive drugs, might take place if the ruling stands.

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New Preventive Services

- For non-grandfathered plans, new preventive services are required to be covered on the first day of the plan year following the one-year anniversary of the new or updated recommendation/guideline for the service.
- New and updated guidelines were issued in December 2021 which means they are effective for plan years beginning January 1, 2023 for calendar year plans.
- Included are:
  - Updated guidelines on breastfeeding services and supplies including double electric breast pumps.
  - Screening for HIV infection for all adolescent and adult women aged 15 and older at least once during their lifetime, and risk assessment and prevention education beginning at age 13.

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New Preventive Services

- Pre-pregnancy, prenatal, postpartum, and interpregnancy well-woman visits.
  - Review any plan exclusion for maternity services for dependents/daughters to make sure preventive pregnancy related services are covered even if other maternity services are excluded.
- Counseling to prevent obesity in women aged 40 to 60 years with normal or overweight body mass index. Previously only covered obesity.
  - Review plan exclusions for weight loss to make sure preventive services are covered.
- The "full range of U.S. Food and Drug Administration (FDA)- approved, -granted, or -cleared contraceptives, effective family planning practices, and sterilization procedures be available as part of contraceptive care."

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Contraceptive Coverage

- On July 28, 2022 the Tri-agencies issued FAQs Part 54 on preventive care services focusing on contraceptives.
- Significant area of Tri-agency concern with repeated FAQs regarding the scope of contraceptive coverage.
  - FAQs Part 51, (Jan. 10, 2022), FAQs Part 31, (Apr. 20, 2016), FAQs Part XXVI, (May 11, 2015), FAQs Part XII, (Feb. 20, 2013).
- Must cover at least one form of contraceptives in each of eighteen categories without cost sharing.
- Cover any FDA-approved, cleared, or granted contraceptive product that an individual and the attending provider determine to be medically appropriate, whether or not specifically identified in the eighteen categories.
- Notes numerous complaints with respect to the lack of coverage and warns of DOL or HHS investigations resulting in re-adjudication of improperly denied claims and possible penalties.

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Proposed Rule on Religious and Moral Objections

- January 30th ***proposed*** rule by the Tri-agencies.
- Background: Under the 2018 final regulations, sponsors of group health plans that have a moral or religious exemption to contraceptive coverage did not have to provide that coverage, but they could provide a ***completely optional*** accommodation where the objecting employer did not have to contract, arrange, pay, or refer an individual for contraceptive coverage, but contraceptive services are still available through an insurer or TPA.
  - Many objecting employers did not provide the optional accommodation.

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Proposed Rule on Religious and Moral Objections

- Proposed rule would provide a new pathway where individuals in plans of objecting employers that did not provide the accommodation could obtain contraceptives at no cost through an "individual contraceptive arrangement" with a willing provider.
- Through that arrangement the provider would be able to seek reimbursements from an insurer on the Exchange who has signed an agreement to provide the coverage. The insurer would then be entitled to an adjustment of an Exchange user fee.

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Proposed Rule on Religious and Moral Objections

- Proposed Rule maintains the existing religious objection.
- Proposed rule would ***eliminate the moral objection***.
- From the Preamble with respect to the application of Religious Freedom Restoration Act (RFRA) to the moral objection :
  - However, there is no such justification for treating non-religious moral objectors in the same manner as religious objectors. RFRA does not require any exemption for non-religious moral objections that do not result in a substantial burden on someone's exercise of religion; therefore, there is no prospect of successful RFRA claims for those entities that might have only non-religious moral objections to contraception. Nor does the existence of the religious exemption compel the conferral of corresponding exemptions based on non-religious moral objections.
- Requests comments on alternatives to full repeal of the moral objection.

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2022 NPRM for Section 1557: Cases to watch

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2022 NPRM for ACA Section 1557

- 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.
- 2022 NPRM applies to insurance issuers as an entity "principally engaged in the business of providing healthcare," including when acting as TPA for self-insured plans.
- 2022 NPRM does not explicitly include GHPs as covered entities because many GHPs are not recipients of federal financial assistance, even if the plan sponsor or TPA are recipients. Complaints against GHPs will be evaluated case-by-case to determine if the GHP is covered under 1557.
- 2022 NPRM adds mechanism to allow for review based on a claim of exemption under a Federal conscience or religious freedom law.
- 2022 NPRM would re-instate several provisions from the 2016 Final Rule that had been removed or amended by the 2020 Final Rule, including incorporating sex stereotypes, sex characteristics, and pregnancy or related conditions in "on the basis of sex", and adding back taglines, notices, and grievance procedures.

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2022 NPRM—Effect on TPAs of Self-Insured Plans

- TPA, any part of which receives federal financial assistance, is covered under 1557.
- "Fact-specific analysis" to evaluate whether TPA is a 1557 covered entity where TPA is "legally separate" from issuer receiving federal funds.
- TPA can also be liable if alleged discriminatory action or plan design originates with TPA.

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Section 1557: Pritchard et al v. Blue Cross Blue Shield of Illinois

- Pritchard et al v. Blue Cross Blue Shield of Illinois—TPA for a self-insured employer with sincerely held religious beliefs (Catholic Health Initiatives) denied claims for gender affirming care. Federal judge rejected TPA's defenses on summary judgement:
  - "Not a covered entity" Defense—court said Chevron deference did not apply because the statutory language was not ambiguous, and 2020 rule is contrary to statute.
  - "No federal funds for TPA activities" Defense—Courts was unpersuaded because activities as an insurance company were taken into account.
  - "Plan Design/ERISA" Defense—Court refused to apply deference to 2016, 2020, or 2022 rules because statutory text contains no exclusion for TPAs that did not design the plan. Also, ERISA 1144(d) states that ERISA will not be construed to alter/invalidate/impair/supersede, etc. any other U.S. law.
    - Query: without the Plan Design defense, does a TPA/insurer have any defense at all under 1557?
  - Religious Freedom Restoration Act (RFRA) Defense—RFRA is not applicable where the government is not a party, and TPA has no sincerely held religious belief.

Section 1557: Circuit Split?

State Medicaid cases to watch in the 4th and 11th Circuits applying *Bostock*:

- 4th Circuit: *Fain v. Crouch* (S.D. West Virginia):
  - Court enjoined state Dept. of Health from applying exclusion of surgical treatment of gender dysphoria in state Medicaid program; program did cover some non-surgical dysphoria treatments (e.g., hormonal)
  - Violates 14th Amendment/equal protection under *Grimm* (4th Circuit 14 A bathroom policy case that applied *Bostock*)
  - Violates 1557 through application of *Bostock*
  - Oral argument schedule for March 7, 2023 at the 4th Circuit
- 11th Circuit: *Dekker et. Al v. Marstiller et al* (filed in N.D. Florida September 2022)
  - New 2022 state Medicaid admin rule excludes all treatment for gender dysphoria
  - Just as with Fain v. Crouch, exclusion is challenged under 14th Amendment, ACA/1557, and Medicaid Act
  - Trial set for district court May 2023

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Stranger Danger:
HIPAA and Online Tracking Technology Vendors

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Online Tracking Technologies and HIPAA: New Guidance

- On December 1, 2022, OCR/HHS issued the bulletin "Use of Online Tracking Technologies by HIPAA Covered Entities and Business Associates"
- Online third-party tracking technologies (e.g., cookies, web beacons, session replay scripts, and fingerprinting scripts) through websites or mobile apps can create HIPAA risks for covered entities. Tracking technology vendors collect and analyze info about user interaction with an entity's websites/mobile app and then send info directly to third-party TT developers, which may continue to track users even after the user navigates to other websites.
- OCR's takes a broad view of PHI: Information collected even from covered entity's publicly accessible webpage could be PHI/ePHI ***even if a user has no current relationship with the covered entity***, and even if the user does not actively provide any specific health care information.
  - How? Because tracking technologies may access identifying info such as IP address or geolocation, and the nature of the user's activity on the website may indicate past, present or future use of health care services.

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Online Tracking Technologies and HIPAA: When is it PHI?

PHI analysis is not formally explained in the Bulletin but seems to hinge on whether the information indicates that the person has received or will receive health care services or benefits from the Covered Entity. Bulletin provides high-level guidance for identifying when information may be PHI:

- User-authenticated Webpage: login or other credentials required for access
  - HHS presumes this info will likely always be PHI
- Unauthenticated Webpage: accessible to general public with no login required
  - Generally, not PHI, but OCR flags some pages as bearing risk:
    - Login/registration page itself, because anyone can access and PHI (e.g., login credentials) is entered
    - Pages that allow for searches of symptoms, health conditions, doctors, or appointments: PHI may be disclosed if this information, along with IP address or email address, is disclosed to the tracking vendor.
    - The Bulletin does not address the scenario where an individual (such as a spouse, parent or guardian) uses a covered entity's public webpage to search for potential providers on behalf of another person (the potential patient).
- Mobile App
  - Apps that assist with health managements or pay medical bills contain PHI when coupled with identifiable info such as fingerprints (i.e., device name, type, operating system version, and IP address), network location, geolocation, device ID, or advertising ID.

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Online Tracking Technologies and HIPAA: Compliance

OCR:

- Disclosures must be permitted under HIPAA Privacy Rules and minimum necessary standard applies
- BA Agreement for tracking technology vendors
- Address tracking technologies in Risk Analysis and Risk Management process and other safeguards under Security Rule
- If the disclosure is not permitted under HIPAA or if the vendor is not a BA, a HIPAA-compliant authorization is needed prior to disclosure
- Breach notification rules apply to unauthorized or impermissible disclosures

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Online Tracking Technologies and HIPAA: Compliance Red Flags

OCR characterizes the following attempts at compliance to be insufficient:

- Notice of the use of tracking technologies in a website or mobile app's privacy policy, notice, or terms and conditions of use is no substitute for a determination that the disclosure is permitted under HIPAA—nor is it a substitute for a BA agreement.
- Website banners that ask users to accept or reject a website's use of tracking technologies, such as cookies, do not constitute a valid HIPAA authorization
- Assurances from an online tracking technology vendor that it will remove PHI or de-identify the info before saving is insufficient and does not negate the need for a HIPAA authorization (unless a BA Agreement is in place and the disclosure is permitted under HIPAA Privacy Rules)
- Signing a BA Agreement does not make a tracking technology vendor a BA if the vendor does not meet the HIPAA definition for a BA.

MHPAEA UPDATES

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David Wit, et al v. United Behavioral Health

- District Court Proceedings
  - Case has generated press coverage and has been closely watched.
  - Originally brought in 2014.
  - Challenge to guidelines for processing mental health and substance use disorder (MH/SUD) claims.
  - Brought as an ERISA fiduciary breach cause of action and did not involve a separate MHPAEA count.
  - The allegations were that underlying coverage determination guidelines for MH/SUD benefits were contrary to the "General Accepted Standards of Care" (GASC) referenced in the plan documents.
  - Ten-day bench trial and in 2019 the California district court entered an extensive 106-page decision finding that the underlying MH/SUD guidelines did violate GASC as well as certain state parity laws for insured claims.

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David Wit, et al v. United Behavioral Health

- District Court Proceedings (cont.)
  - In 2020, ordered the reprocessing of 67,00 MH/SUD claims (stayed pending appeal).
  - $19.6 million in attorneys' fees awarded in January 2022.
  - Unique questions on whether reprocessing (without a showing of entitlement to benefits) was appropriate equitable relief under ERISA and whether it could form the basis for class certification since the results of that reprocessing would be different for different members of the class.
- Ninth Circuit Court of Appeals Decision (*unpublished*)
  - March 22, 2022, unpublished (nonprecedential) decision reversed the district court.
  - Whether the guidelines violated GASC was not determinative.
  - While the plans at issue did not cover services inconsistent with GASC, the Ninth Circuit determined that did not answer the question because even certain services that were consistent with GASC were still excluded by other specific plan provisions.
    - For example, Defendants alleged that certain custodial care services could be consistent with GASC but those services were still specifically excluded by the plan documents.

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David Wit, et al v. United Behavioral Health

- Ninth Circuit Court of Appeals Decision (*published*)
  - January 26, 2023, published opinion replaces prior unpublished opinion
  - Appeals court reversed the district court order requiring the reprocessing of 67,00 MH/SUD claims.
  - Whether the guidelines violated GASC was not determinative, court looked at whether the claims were properly administered pursuant to plan terms
  - ERISA does not mandate consistency with GASC
  - Reprocessing not appropriate remedy under ERISA 502(a)(1)(B)

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Miscellaneous

- Consolidated Appropriations Act, 23, eliminates the right of self-funded, non-federal governmental health plans to opt out of MHPAEA compliance
  - Effective December 29, 2022
  - Elections expiring 180 days or more after December 29, 2022 may not be renewed.
- Still waiting for the following:
  - NQTL report from Congress due in October 2022
  - Self-compliance tool updates
  - NQTL regulations

IDR Developments

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Developments-Litigation

- Texas Medical Association filed lawsuit early in 2022 regarding the interim final rule's presumption that QPA was the appropriate amount
  - Texas District Court vacated that portion of the rule as a violation of the APA
- Agencies issued new rule that was effective October 2022
  - Agencies intended to address the QPA presumption issue
  - Texas Medical Association filed suit again saying that new rules fail to address the issue
  - Now, TMA is also attacking the QPA methodology

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Developments-Miscellaneous

- Agencies changed the non-refundable administrative fee from $50 to $300 for 2023 calendar year.
- 46,000 IDR's initiated in first quarter following April 15 launch

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Miscellaneous

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Disaster Relief Filing Extensions

- Weather-related disasters extended several filing deadlines, one of the latest being CA-2023-02. Those in FEMA-designated areas (victims of severe winter storms, flooding, landslides, and mudslides) beginning December 27, 2022, now have until May 15, 2023, to file various individual and business tax returns and make tax payments:
  - CA-2023-01 and 02, victims of severe winter storms, flooding, landslides, and mudslides in CA
  - AL-2023-01, victims of January 12 severe storms, straight-line winds, and tornadoes in AL
  - GA-2023-01, victims of severe storms, straight-line winds, and tornadoes in GA
  - IR-2023-09, IRS: GA, AL storm victims
  - IR-2023-03, IRS: CA storm victims
- 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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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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DOL 2023 Adjusted Penalties for H&W Violations

2023 Penalties Assessed after January 15, 2023:

- Form 5500: $2,586/day, up from $2,400
- For M-1: $1,881/day (applies to multiple employer welfare arrangements), up from $1,746
- SBC: $1,362/per failure, up from $1,264
- DOL document request: $184/day, with a mx of $1,846 per occurrence, up from $171/$1,713
- CHIP Notice: $137/day, up from $127

Questions