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Law & Policy Group | GRIST

Top 10 compliance issues for health and leave benefits in 2023

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Health and leave benefit compliance issues for 2023

In 2023, employers will continue to focus on complying with transparency requirements designed to provide greater insight into the prices of prescription drugs and other healthcare. Other issues in the spotlight include health plan coverage of gender, family planning (including abortion) and behavioral health. With respect to gender and family planning, employer-sponsored health plans must comply with rapidly changing federal and state laws and regulations, assess litigation risks, and offer health coverage that aligns with employees' needs and the employer's diversity, equity and inclusion (DEI) goals. Employers may want — or have — to expand behavioral health coverage in response to the nation's mental health crisis and tougher enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA).

This GRIST summarizes expected 2023 compliance and policy developments affecting health and leave benefits and suggests action steps for employers. Topics covered include:

- **Congressional outlook.** November's midterm elections and the possibility of new majorities in the next Congress will have important repercussions for healthcare policy in 2023. In the meantime, lawmakers are eyeing a potential healthcare package that could pass with bipartisan support this year in a post-election lame-duck session or carry over to 2023. Proposals of interest to employers would extend telehealth flexibilities, improve care for mental health and substance abuse, provide greater transparency into pharmacy benefit manager (PBM) practices, increase employer penalties for MHPAEA noncompliance, codify federal protections for same-sex marriages, and require parity for kidney dialysis benefits relative to benefits for other chronic medical conditions.
- **Regulatory outlook.** The Biden administration is likely to continue aggressively using its executive authority and regulatory tools to push its policy goals. Watch for enforcement activity and guidance on implementing the MHPAEA, the Affordable Care Act (ACA) and the transparency reforms enacted by the 2021 Consolidated Appropriations Act (2021 CAA), including the ban on surprise billing and prescription drug data collection (RxDC) reporting. The high cost of prescription drugs will remain in focus. In addition, the COVID-19 public health emergency (PHE) and national emergency (NE) will likely conclude in 2023, leaving health plans to unwind various temporary measures either permitted or mandated by law or regulators.
- **Litigation outlook.** Litigation may limit the Biden administration's efforts to expand healthcare reforms. Challenges to existing healthcare reforms pending in the courts target the ACA's preventive services mandate, surprise billing regulations and ACA Section 1557 nondiscrimination regulations.
- **State outlook.** At the state level, employers can expect states to implement paid leave laws and prescriptions drug pricing reforms, among other health coverage mandates.

Congressional outlook

A number of bipartisan proposals have a chance of making it into 2022 year-end legislation, despite midterm election tensions and Republican anger over the Inflation Reduction Act (IRA) (Pub. L. No. 117-169), the Democrats' budget reconciliation bill recently enacted on

party-line votes. While the new law makes big changes to Medicare prescription drug pricing and coverage, the act's provisions generally don't directly affect employer plans. The legislation also drops many employer-focused proposals contained in earlier, more expansive versions of the bill known as the Build Back Better Act.

Outlook for healthcare proposals with bipartisan support

Democrats' nearly two-year focus on achieving their policy goals through the reconciliation process without Republican support has fueled pent-up demand for final action on several bipartisan priorities. Though Congress has gone home to campaign ahead of the midterm elections, lawmakers are actively considering the contours of a healthcare package that could hitch a ride on an omnibus year-end measure to keep the government running when current funding expires on Dec. 16. That package could include proposals on telehealth, mental health, same-sex marriage rights, insulin costs and kidney dialysis benefits.

Extension of telehealth flexibilities. Lawmakers want to extend a telehealth provision in the Coronavirus Aid, Relief and Economic Security (CARES) Act (Pub. L. No. 116-136) that allows:

- Employers to offer predeductible coverage of telehealth and other remote care services in health savings account (HSA)-qualifying high-deductible plans (HDHPs)
- Otherwise HSA-eligible individuals to receive predeductible coverage for telehealth and other remote care services from a stand-alone vendor outside of the HDHP

Neither type of predeductible telehealth coverage will jeopardize an individual's eligibility to make or receive HSA contributions while the temporary relief is in place. The relief originally applied for plan years starting on or before Dec. 31, 2021. Congress extended this relief in the 2022 Consolidated Appropriations Act (2022 CAA) (Pub. L. No. 117-103), but only from April 1 through Dec. 31, 2022 — not retroactively to Jan. 1, 2022. Bipartisan bills (HR 5981, S 1704) would make this relief permanent, although another temporary extension, perhaps for two years, appears more likely.

Congress may also extend the temporary PHE relief that treats stand-alone telehealth benefits and other remote care services for benefits-ineligible employees (e.g., part-time or seasonal workers) like an excepted benefit, exempt from many ERISA and ACA group health plan mandates. Unlike the temporary relief, the legislation (HR 7353) would let all employers, regardless of size, offer excepted-benefit stand-alone telehealth arrangements to all employees, not just those ineligible for benefits.

Mental healthcare. Mental health advocates are optimistic that Congress will include behavioral health reforms in a year-end package, as House and Senate committees have recently made progress on several related bills. A leading proposal in Congress is House-passed bipartisan legislation (HR 7666) that would reauthorize and expand a number of federal programs meant to support behavioral healthcare and workforce training. The bill wouldn't directly affect private employers' programs but would require self-funded, nonfederal governmental plans to comply with mental health parity laws. It would also require PBMs to report a wide range of data about their business practices to plan sponsors and the government at least every six months. Reportable data would include how the PBM sets rebates and discounts and what it pays for drugs. Those provisions have bipartisan support and backing from employers and stand a good chance of landing in any final mental health measure this year.

Another House-passed bill (HR 7780) from Democrats has potentially adverse implications for employers but faces headwinds in the Senate. Provisions would boost Department of Labor (DOL) funding for enforcement, expand the ability of DOL and others to sue plans and health insurers for mental health parity violations, and let DOL impose civil monetary penalties for MHPAEA violations. The bill would also ban arbitration clauses, class action waivers, and clauses granting discretion to determine benefits or interpret ERISA plan terms.

Same-sex marriage rights. A push to pass a bill establishing a federal statutory right to same-sex marriage stalled earlier this year but looks set to resume when lawmakers return in November. When the Supreme Court earlier this year ended the federal constitutional right to abortion (*Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022)), a concurring opinion by Justice Clarence Thomas suggested that the court should revisit past decisions undergirding same-sex marriage. In response, the House passed a bill (HR 8404) to mandate that states honor out-of-state marriages, regardless of a couple's sex, race, ethnicity or national origin. The effort hit a roadblock in the Senate, where some Republicans raised religious liberty concerns. But the bill's supporters, including several GOP senators, are optimistic about winning the 60 votes needed for passage once the election dust has settled and the political pressure on outgoing lawmakers has lifted.

Cap on insulin costs. Senators from both parties are eyeing the lame-duck session for action on capping consumers' out-of-pocket costs for insulin in the commercial market, though the outlook is uncertain. A bipartisan Senate proposal floated earlier this year would cap consumer copays for insulin in the commercial market at $35 a month and incentivize drugmakers to lower list prices. However, the nonpartisan Congressional Budget Office projects that the bill's curbs on insurers' ability to negotiate net prices and potential increased spending on insulin products would raise premiums for Medicare and employer plans, dimming chances for final action this year.

Parity for kidney dialysis benefits relative to other chronic care benefits. Bipartisan House and Senate bills (HR 8594, S 4750) that could see action this year would amend the Medicare secondary payer (MSP) statute to require that employer plans cover kidney dialysis benefits in parity with benefits for other chronic medical conditions. The bills seek to undo the Supreme Court's holding in *Marietta Memorial Hospital Employee Health Benefit Plan v. DaVita Inc.* (142 S. Ct. 1968 (2022)). The decision found that a health plan with limited dialysis benefits does not violate the MSP statute if the plan's terms apply uniformly to all enrollees and don't vary based on end-stage renal disease or Medicare eligibility or entitlement.

The legislation has triggered a fierce lobbying fight. Plan sponsors argue that legislation requiring parity between kidney failure and other chronic conditions is tantamount to an expensive in-network coverage mandate. Market concentration in the dialysis industry would make that mandate even more costly for plan sponsors. Dialysis providers and patient groups counter that letting the court decision stand will encourage plans to restrict dialysis coverage to cut costs, adding to Medicare's financial burden. A CBO score of the bills could project major savings for the government, giving supporters of the bills a powerful talking point.

Midterms may elevate GOP agenda but major reforms unlikely

A likely divided government in 2023 means less ability for either party to push through major reforms. Nevertheless, Congress will have an opportunity to act on any bipartisan legislative

leftovers from 2022 and find compromise on additional issues. Those issues include encouraging telehealth, enhancing transparency, barring anticompetitive contracting terms between providers and health plans, improving care for mental health and substance use disorders, and updating HSA/HDHP rules to better coexist with direct primary care arrangements and increase the flexibility to offer first-dollar coverage. While both parties support paid leave, the partisan divide in approach makes enactment of a federal mandate unlikely.

If Republicans win control of either/both the House and Senate, their power will be checked by the president's veto. Overriding a veto requires a two-thirds majority of the Senate, something Republicans won't have. In any case, the GOP has turned away from trying to repeal/replace the ACA and is not offering detailed healthcare policy plans. House Republicans' recently released Commitment to America agenda, however, calls for expanded access to telehealth and "lower prices through transparency, choice, and competition."

If Democrats keep control of both chambers and expand their 50-seat Senate majority, they may try to bring back proposals dropped from the 2021 budget reconciliation proposal, the Build Back Better Act. Those proposals include a federal paid leave entitlement, a lower ACA affordability threshold for employer plans and DOL's ability to assess civil monetary penalties on employers for mental health parity violations. A major priority, however, would focus on helping the Biden administration implement the IRA's extensive Medicare drug pricing and Part D reforms.

2023 health and leave benefit planning

This list highlights 10 top compliance-related priorities for planning 2023 health, leave and fringe benefits and recommends general actions for each item. The links below take readers to more detailed information. The appendix provides resources related to each compliance topic.

1. **Prescription drugs.** Watch for federal legislative and regulatory efforts to curb drug and insulin prices and increase access, especially in light of a recent presidential directive. Monitor ongoing state efforts to restrict PBM activities and cap participant cost sharing for insulin and other commonly used drugs. Prepare to comply with a new prescription drug reporting requirement under Section 204 of the No Surprises Act (NSA), part of the 2021 CAA. The interim final rule (IFR) set an initial deadline of Dec. 27, 2022, for the 2020 and 2021 reporting years. Follow the progress of the Federal Trade Commission (FTC) investigation of six major PBMs, whose practices have drawn considerable attention in recent years.

2. **Group health plan transparency.** Prepare to make available the self-service cost comparison tool required under the final transparency-in-coverage (TiC) rule for group health plans and insurers beginning with the plan year that starts on or after Jan. 1, 2023. Confirm that machine-readable files (MRFs) are updated monthly with accurate and complete in-network provider rates and out-of-network allowed payments. When possible, look for analyses of the healthcare prices made public by hospitals since 2021 under the final transparency regulation for hospitals and by third-party administrators (TPAs) and insurers since July 2022. Ensure that the 2021 CAA's required prescription drug reporting is timely submitted in 2022 and 2023. Watch for more guidance on the remaining transparency requirements — especially the advanced explanations of benefits (EOBs) — and continue good-faith efforts to comply in the interim. Work with vendors to

ensure compliance, and update contracts as necessary — most plan sponsors don't have the required information for the new disclosures. Consider negotiating performance guarantees related to transparency compliance.

3. **Mental health parity.** Continue to comply with the MHPAEA. Ensure that the plan has a written comparative analysis of all nonquantitative treatment limits (NQTLs), as required by the 2021 CAA. Review the plan for NQTLs that have triggered litigation and agency scrutiny. Include assistance with NQTL comparative analyses in requests for proposals (RFPs) and vendor contracts. In 2023, watch for new legislation, guidance and the agencies' report to Congress, as well as ongoing and emerging parity and behavioral health coverage litigation. Consider MHPAEA parity requirements when improving a group health plan's medical or surgical benefits.

4. **COVID-19 pandemic winds down.** In anticipation of the COVID-19 PHE and NE ending in 2023, review group health plan terms for COVID-19-related coverage, including testing, vaccines and treatment. Review benefit terms or offerings made under temporary COVID-19 relief laws and guidance. When agency relief during the COVID-19 NE expires, confirm proper winding down of extended deadlines for claims and appeals, special enrollment under the Health Insurance Portability and Accountability Act (HIPAA) and continuation coverage elections and payments under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Review federal, state and local COVID-19 guidance on employee health and safety, leave, and workplace nondiscrimination, and review related policies as many of these requirements expire. Monitor federal legislation that could extend COVID-19 testing requirements or telehealth flexibilities.

5. **Gender and family planning issues in benefits.** Assess the health plan impact of the Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision. Employers considering enhanced fertility, adoption and surrogacy benefit programs to support DEI goals and the needs of a diverse workforce should be mindful of compliance issues, including federal tax laws, the ACA and state laws. Review contraceptive coverage to confirm compliance with recent agency guidance. Consider whether federal or state laws require benefit changes for LBGTQ employees and their family members.

6. **Surprise billing.** Confirm plan administrators are complying with the ban on surprise billing for emergency services, air ambulances and certain nonemergency services covered by the NSA. Verify that emergency services are covered to the extent required by the NSA, and plan documents have corresponding updates. Make sure plan documents also contain the necessary cost-sharing information for all services protected by the NSA. Confirm the latest required surprise billing notice is posted on a public website and included with EOBs. Review the frequency and outcomes of independent dispute resolution (IDR) processes. Consider the appropriateness of additional vendor fees related to surprise billing compliance and/or any shared-savings program charges.

7. **State-mandated paid leave and other state law trends.** Review state laws impacting group health and benefit plans. Look for more benefit mandates for fully insured plans. State initiatives will likely include legislative action and agency rule-making on paid family and medical leave (PFML) and paid sick leave, more state restrictions on PBMs for both fully insured and self-funded plans and changes to telehealth laws. Prepare for 2023 reporting obligations. Monitor an ERISA preemption challenge currently pending before the US Supreme Court involving to Seattle's hotel employee healthcare ordinance and other ERISA-related challenges, particularly to state abortion laws.

8. **Preventive services.** Confirm nongrandfathered group health plans cover all ACA-required in-network preventive services without any deductible, copay or other cost sharing. Modify preventive benefits for the 2023 plan year to reflect new or revised recommendations from the US Preventive Services Task Force (USPSTF), the Health Resources & Services Administration (HRSA), the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and ACA guidance. Watch for new COVID-19 preventive services or vaccines, which nongrandfathered health plans must cover without cost sharing on an expedited time frame. Determine the starting age for mandated coverage of breast cancer screening without cost sharing. Ensure coverage of ACA-mandated women's contraceptives approved by the Food and Drug Administration (FDA), unless the employer has religious or moral objections to contraceptives. Monitor litigation that could spare employer plan sponsors with religious objections from covering preexposure prophylaxis (PrEP) HIV medications and all nongrandfathered group health plans and insurers from covering ACA-mandated USPSTF-recommended preventive services without cost sharing. Track litigation that could require group health plans and insurers to continue covering instruction in fertility awareness-based methods. Update plan documents, summary plan descriptions (SPDs), summaries of benefits and coverage (SBCs), and other materials as needed.

9. **Other ongoing ACA concerns.** Review 2023 group health plan coverage and eligibility terms in light of employer shared-responsibility (ESR) strategy, ESR and minimum essential coverage (MEC) reporting duties, and ACA benefit mandates. Consider the plan impact (if any) now that the "family glitch" for affordable coverage is fixed. Ensure that any rehired retirees are not covered under a "retiree only" plan exempt from many ERISA and ACA requirements. Comply with new obligations under the ACA Section 1557 rules. Continue to calculate and pay the Patient-Centered Outcomes Research Institute (PCORI) fee for self-funded health plans, and prepare for medical loss ratio (MLR) rebates. Monitor ongoing litigation challenging various ACA provisions, including the obligation for nongrandfathered group health plans to cover USPSTF-recommended preventive services without participant cost sharing.

10. **Health savings account (HSA), health reimbursement arrangement (HRA) and flexible spending account (FSA) developments.** For 2023, discontinue changes made by temporary COVID-19 relief, unless extended or made permanent by future legislation or agency guidance. Decide whether to continue (or to adopt) the permanent enhancements to account-based plans under the CARES Act (Pub. L. No. 116-136), the IRA (Pub. L. No. 117-169) and IRS guidance. Amend cafeteria plans under Internal Revenue Code (IRC) Section 125 for changes implementing COVID-19 relief; final amendments for calendar-year plans generally are due by Dec. 31, 2022, but noncalendar plans may have until the last day of the 2022–2023 plan year for certain amendments. Update HDHPs and account-based plans for indexed dollar limits. Identify pre- or no-deductible health benefits, programs or point solutions that could jeopardize an individual's eligibility for HSA contributions, and confirm strategy. Consider whether pending IRS regulations on individual-coverage HRAs (ICHRAs) or direct primary care arrangements (DPCAs) will impact benefit strategies and compliance efforts. Review future IRS guidance on the definition of a tax dependent for any impact on account-based plans.

Section 1
Prescription drugs

Action

Watch for developments related to a recent executive order aimed at lowering drug costs and expanding access. Monitor federal activity on prescription drug and insulin costs, particularly for Medicare and Medicaid coverage, which may influence drug costs for employer-sponsored coverage. Track state legislative and regulatory efforts to restrict PBM activities, particularly any limitations affecting both fully insured and self-funded plans in light of recent ERISA preemption case law. Prepare to comply with the RxDC reporting requirement. The first report is due Dec. 27, 2022, but starting in 2023, annual reports will be due every June 1. Coordinate with insurers, TPAs and other vendors to ensure that all data files and narrative responses are properly submitted. Track the FTC investigation into six large PBMs' impact on prescription drug access and affordability.

Specific steps

Pay attention to how the US Department of Health and Human Services (HHS) responds to October's Executive Order 14087 on lowering prescription drug costs. The president directed HHS — by mid-January 2023 — to test new healthcare payment and delivery models that could decrease drug costs and increase access to innovative drug therapies.

Follow developments related to prescription drug and insulin costs, especially with the installation of a new Congress in 2023.

- **Keep tabs on IRA developments.** The law authorizes the Centers for Medicare & Medicaid Services (CMS) to negotiate drug prices for Medicare plans. In addition, the IRA makes plan design changes to the standard Medicare Part D benefit that will take effect in later years.
- **Monitor federal legislative proposals to extend insulin cap.** Look for bills that seek to extend the IRA's Medicare $35 monthly cap on cost sharing for insulin to group health plans.
- **Track federal PBM transparency legislation.** Watch for bills that mirror the proposals in S 4293, the Pharmacy Benefit Manager Transparency Act, introduced in 2022. The bill cleared a Senate committee before stalling. If enacted, the measure would have banned spread pricing and required extensive PBM disclosures and reporting.
- **Look for developments in the wake of the US Supreme Court's Section 340B decision.** Keep an eye on CMS actions resulting from the Supreme Court's decision in *American Hospital Association v. Becerra* (142 S. Ct. 1896 (2022)). The ruling held that the government unlawfully applied reimbursement rates for 340B hospitals in 2018 and 2019. The impact of the decision could affect drug prices in future years. In addition, pharmaceutical manufacturers are in ongoing discussions with hospitals and PBMs about the program. These discussions may result in operational changes in the near future.

Work with insurers, PBMs and TPAs to address state initiatives affecting plan design and costs.

- **Review PBM contracts.** Examine compliance with applicable state laws and implementing regulations, particularly in states that have enacted legislative changes in the past year. Those states include Alabama, Arizona, Colorado, Delaware, Florida, Illinois, Indiana, Iowa, Louisiana, Maine, Minnesota, New Hampshire, North Carolina, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, Vermont, West Virginia and Wisconsin.
- **Monitor state efforts to cap insulin costs.** Look for more states — such as Louisiana, Maryland, Oklahoma and Washington — to implement insulin caps for fully insured plans.
- **Watch for state attempts to further restrict PBM activities.** Keep an eye on proposed laws that would limit or prohibit practices like white bagging (providing prescription drugs at the site of care), brown bagging (providing prescription drugs through a specialty pharmacy), and other price-saving programs for fully insured and self-funded plans. In particular, Georgia, Kentucky, Maine, Minnesota, Missouri and Wisconsin considered such bills in 2022. Seven states — Colorado, Maine, Maryland, New Hampshire, Ohio, Oregon and Washington — have prescription drug affordability boards that could implement substantive rules affecting PBM activities.

Monitor court rulings addressing ERISA preemption of state PBM laws that include self-funded plans within their scope.

- **Track post-*Rutledge* state efforts.** Determine to what extent new state PBM laws affect self-insured ERISA plans in the aftermath of the US Supreme Court's *Rutledge v. Pharmaceutical Care Management Association* decision (140 S. Ct. 812 (2020)). The ruling held that ERISA does not preempt an Arkansas law regulating the cost paid by PBMs to pharmacies. Since then, ERISA preemption challenges to state PBM legislation have failed in two other cases:
  - *Pharmaceutical Care Management Association v. Wehbi*, 18 F.4th 956 (2021)
  - *Pharmaceutical Care Management Association v. Mulready*, No. 5:19-cv-00977-J (WD OK April 4, 2022)

Build a sustainable, compliant approach to RxDC reporting.

- **Ensure timely filing.** Confirm that the initial filing occurs by Dec. 27, 2022, in a complete and accurate manner by all entities that commit to submitting data through the Health Insurance Oversight System (HIOS) application, available on the CMS Enterprise Portal. Monitor each vendor's or insurer's processes and ability to comply by the applicable deadline going forward.
- **Address ongoing compliance concerns for the 2020 and 2021 submissions.** Review contracts with insurers, TPAs, PBMs and other vendors as needed:
  - If your plan is insured, your insurer should make the entire submission on your behalf, but confirm that understanding in writing with the insurer.
  - If your plan is self-funded, consider whether to require that vendors submit the various files on your behalf.

    - Review any updates to instructions or other guidance that may require you to change the approach to the RxDC submission due in June 2023.
    - Consider whether vendor contracts should require the vendor to provide a copy of the plan-level data files (D1–D8) and the narrative response. This may become necessary if CMS instructions or other guidance requires plans to combine data from all vendors and submit one set of unique files.
  - Decide whether to submit certain files. Consider whether to submit potentially the P2 file or the D1 file to CMS yourself, and whether to file an optional supplemental document or connect with CMS to explain any uncooperative vendors.
  - Review contractual protections. Determine if RxDC reporting and cooperation are adequately addressed (for example, through provisions on indemnification and performance guarantees), particularly in the event of a reporting failure.

- **Decide whether to shift responsibility for submission of specific data files.** Regardless of the approach taken for the 2020 and 2021 submissions, consider transferring responsibility from or to insurers, TPAs, PBMs and other vendors. Large employers may have sufficient resources to handle the HIOS submission and assess the prescription drug data to make better plan design decisions.
- **Watch for additional changes and possible litigation.** Stay up to date on CMS changes to the instructions, FAQs or guidance and any additional good-faith compliance relief. Very limited relief currently is available for one field (average monthly premium paid by employers and employees (defined as members in the instructions)) in one data file (the D1 file on premiums and life-years).

Address any PBM repercussions or changes resulting from the FTC probe.

- **Consult with PBMs.** Follow up with the plan's PBM on what impact, if any, the FTC investigation of six major PBMs will have on plan design and costs. The inquiry's focus includes PBM fees and clawbacks, patient steering, pharmacy reimbursements and specialty drug practices.
- **Track similar state developments.** Stay abreast of any state investigations similar to the FTC inquiry.

Related resources

Section 2

Group health plan transparency

Action

Prepare to make available the self-service cost comparison tool required under the final TiC rule for group health plans and insurers beginning with the plan year that starts on or after Jan. 1, 2023. Confirm that MRFs are updated monthly with accurate and complete in-network provider rates and out-of-network allowed payments. When possible, look for analyses of the healthcare prices made public by hospitals since 2021 under the final transparency regulation for hospitals and by TPAs and insurers since July 2022. Ensure that the 2021 CAA's required prescription drug reporting is timely submitted in 2022 and 2023 (see Prescription drugs for more information). Watch for more guidance on the remaining transparency requirements — especially the advanced EOBs — and continue good-faith efforts to comply in the interim. Work with vendors to ensure compliance, and update contracts as necessary — most plan sponsors don't have the required information for the new disclosures. Consider negotiating performance guarantees related to transparency compliance.

Specific steps

Review the final TiC rule and later enforcement relief for group health plans and insurers, and continue complying in 2023. Determine which plan service providers will supply required data for the self-service transparency tool and how they will deliver this data. Consider using a transparency vendor to develop the self-service tool or provide a consolidated tool. Decide whether to include optional quality metrics along with the required price information in the self-service tool. Most plans made great strides to comply with the MRF requirement in 2022, but some MRFs appear to be works in progress. Plans should continue to comply with the MRF requirements, including recordkeeping and monthly updates. Plan sponsors should consider each of these requirements when onboarding new vendors. Communicate the rollout of the self-service tool to plan participants, and update language in the plan document and SPD as necessary.

- **Ensure compliance with the TiC rule.** The TiC rule doesn't apply to grandfathered plans, HRAs, excepted benefits, expatriate plans exempt from ACA provisions, retiree-only plans or short-term limited-duration insurance. The rule requires other group health plans, including self-funded plans and health insurance issuers, to take two key actions:
  - **Provide a self-service cost transparency tool for 500 covered services and items for plan years beginning on or after January 2023 and for all covered services and items by the 2024 plan year.** The list of 500 items and services to include in the first phase of implementing the internet-based self-service tool is available on the TiC website at www.cms.gov/healthplan-price-transparency/resources/500-items-services. Plans and issuers should refer to this webpage for the most up-to-date list of codes to use in the self-service tool for plan years beginning on or after Jan. 1, 2023, and before Jan. 1, 2024. Regulators will update the list quarterly and provide reasonable time for plans and issuers to update their self-service tools accordingly. (As discussed later, the 2021 CAA also requires a price comparison tool, but regulators have delayed enforcement of this requirement to

align it with the self-service cost transparency tool.) Plan participants must have access to the internet-based self-service tool, which must provide a variety of information and:

- Disclose personalized out-of-pocket costs for all covered healthcare items and services (with paper copies available on request)
- State any applicable prerequisite
- Give an estimate of a participant's cost-sharing liability for any in- or out of-network provider, allowing the participant to compare costs before receiving medical care
- Enable searching by billing code, descriptive terms, in-network provider name and other relevant factors (like geography)
- Track a participant's accruals toward any cumulative treatment limitations (like day or visit limits) as well as deductibles and out-of-pocket maximums
- Include required disclosures (DOL has provided a draft model notice)

— **Make MRFs available on a public website**, starting with plan years beginning on or after January 2022, subject to the enforcement delays described below. The final TiC rule requires standardized MRFs, updated monthly, containing the plan's negotiated rates for in-network providers, past allowed payments to out-of-network providers and prescription drug information.

- **Make sure MRFs are timely posted.** The final TiC rule requires posting MRFs with in-network rates and out-of-network allowed amounts and billed charges for plan years beginning on or after Jan. 1, 2022, but regulators deferred enforcement until July 1, 2022. Plans with noncalendar plan years beginning after July 1, 2022, must post files by the first day of the 2022–2023 plan year.
- **Confirm that MRFs are updated monthly** with accurate and complete in-network provider negotiated rates and out-of-network allowed payments. CMS has provided a schema and helpful discussions on GitHub that developers must follow in preparing the MRFs. Ensure all data elements for the negotiated rate file and the allowed amounts file are included in the applicable MRF.

  — **Public posting.** If a group health plan does not have a website, agency guidance allows the plan to enter into a written agreement to have the plan's insurance issuer or TPA post the information on its public website for participants, beneficiaries and enrollees. The plan satisfies the posting requirements only if the health insurance issuer or TPA makes the information available in the required manner. This guidance applies when the plan sponsor (for example, an employer) maintains a public website, but the employer's group health plan does not.

  – **Recordkeeping.** MRFs must be updated monthly (reasonably consistent periods of approximately 30 days) and clearly indicate the date of the most recent update. The TiC rule doesn't have a specific retention requirement, but separate guidance addresses recordkeeping. The guidance recommends that group health plans and health insurance issuers maintain prior months' MRFs to demonstrate compliance with the TiC rule. In addition, other federal laws

may affect MRF retention, such as laws governing the accessibility, privacy or security of information or requiring properly authorized representatives to have access to participant, beneficiary, or enrollee information held by plans and issuers. States may have their own recordkeeping and retention requirements for certain health insurance plans and issuers.

- **Alternative reimbursement arrangements.** Regulators have provided an enforcement safe harbor for plans and issuers that use certain alternative reimbursement arrangements. The safe harbor applies when an alternative reimbursement arrangement does not enable plans and issuers to derive accurate and specific contracted dollar amounts for covered items and services before they are provided. The safe harbor also applies when an alternative reimbursement arrangement cannot disclose specific dollar amounts according to the schema in the technical implementation guidance on GitHub.

- **Watch for guidance on posting MRFs with prescription drug prices.** The agencies have delayed this requirement while they determine whether it remains appropriate in light of the reporting on pharmacy benefits and drug costs mandated by the 2021 CAA. Under the 2021 CAA, plans should prepare to report 2020 and 2021 prescription drug data by Dec. 27, 2022, and 2022 data by June 1, 2023 (see Prescription drugs for details).

- **Review the impact on potential MLR rebates (insured plans only).** To encourage consumers to shop for better prices, the rule allows insurers to reduce MLR rebates if insured plans share cost savings with enrollees who choose less-expensive providers.

- **Avoid potential penalties.** Unlike the 2021 CAA requirements discussed below, group health plans do not have good-faith relief from enforcement of the TiC rule. Group health plan sponsors failing to meet the TiC rule could face penalties of $100 per day per participant. However, many group health plan sponsors don't have access to all negotiated prices and can't provide the transparency disclosures without input from the plan's insurer or TPA. The rule offers some relief to sponsors in that situation:

  - A safe harbor spares an employer with a fully insured group health plan from having to provide the transparency disclosures to participants, as long as a written agreement requires the insurer to do so. If the insurer fails to provide the required information, the insurer — not the group health plan — will face liability for the violation. Employers with insured plans should ensure that their insurers provide such a written agreement.

  - The rule also provides relief for group health plans that make an error or omission or are unable to obtain complete or accurate information from another entity, despite acting in good faith and with reasonable diligence. Group health plans likewise won't face penalties if the website hosting the transparency tool and files is temporarily inaccessible. In both cases, the plan must correct the problem as soon as practicable.

Review and comply with the 2021 CAA's transparency requirements and the agencies' enforcement relief. Look for additional guidance on several 2021 CAA transparency

topics in 2023. The 2021 CAA's requirements, unless otherwise noted, generally took effect for the 2022 plan year and include the following:

- **Price comparison tool.** Plans and insurers must provide a price comparison tool similar to the self-service price transparency tool required by the final TiC rule (discussed above). The tool must be available by telephone and on the plan or issuer's website. To the extent practicable, the tool must allow participants to compare the cost sharing that they will owe for a specific item or service obtained from a participating provider in a particular plan year and geographic region. Originally required for the 2022 plan year, the 2021 CAA's price comparison tool is "largely duplicative," according to regulators. They delayed enforcement until the 2023 plan year to align the 2021 CAA's price comparison tool with the TiC rule's self-service cost transparency tool. However, regulators have yet to issue guidance that would align the two requirements.

- **Air ambulance reporting**. The 2021 CAA requires group health plans and issuers to report claims data for air ambulance services. HHS and the Transportation Department must use that data to produce a comprehensive, publicly available report on air ambulance services. This report is expected to help shed light on what's driving the high costs of these services. Proposed rules issued in September 2021 would require reporting air ambulance data for calendar year 2022 by March 31, 2023, and data for calendar year 2023 by March 30, 2024. Employers should watch for final rules with more information on air ambulance reporting.

- **Advanced EOBs (enforcement delayed).** Healthcare providers and facilities will have to provide group health plans a good-faith estimate of expected charges when an enrollee schedules a specific item or service. A group health plan that receives such a notification or a request from a participant has to meet tight time frames to provide an advanced EOB with detailed information about the plan's coverage of the scheduled item or service. The agencies are delaying enforcement of this provision, pending publication of regulatory guidance. Regulators have asked for comments about implementing the new requirement.

- **Disclosures on health plan ID cards.** Physical or electronic health plan ID cards must include any applicable deductible or out-of-pocket maximum, along with a telephone number and website address for obtaining consumer assistance. Consumer assistance may include information on hospitals and urgent care facilities that have a contractual relationship for furnishing items and services under the plan. Regulators expect good-faith compliance until regulations are issued.

- **Up-to-date provider directories.** Group health plans must provide an accurate, verified database on their public website that contains a list of and directory information on each healthcare provider and facility that has a direct or indirect contractual relationship with the plan. Group health plans also must prepare to respond to participant questions about the provider directory. If this database incorrectly lists an out-of-network provider as in-network and a participant or beneficiary obtains items or services from that provider, the plan must limit cost sharing to the in-network amount and credit that amount toward the in-network deductible or out-of-pocket maximum. Until regulations come out, regulators expect group health plans to show good-faith compliance by limiting charges for out-of-network care (as described above) when an enrollee receives inaccurate information about a provider's network status.

- **Broker and consultant disclosures.** Brokers and consultants expecting to receive at least $1,000 for their services will have to disclose to group health plans all direct and indirect compensation for those services. Regulators issued an enforcement policy regarding broker and consultant disclosures: Pending future guidance or regulations, covered service providers and plan fiduciaries generally are expected to implement the disclosure requirements using a good-faith, reasonable interpretation of the law. DOL considers that a good-faith and reasonable step is for a group health plan's service provider to take into account the department's July 16, 2010, and Feb. 3, 2012, pension plan guidance on this topic.
- **Ban on gag clauses that prohibit sharing price and quality information (effective Dec. 27, 2020).** Plan sponsors need to attest that none of their plan-related contracts has such a gag clause. Regulators intend to issue additional guidance about when and how to submit these attestations.

Review the final hospital transparency rule to understand what rates hospitals had to begin disclosing in 2021. Work with relevant experts — e.g., data specialists or clinician — to understand the hospital data. Look for additional hospital disclosures as enforcement against noncompliant hospitals increases.

- **Examine how annual price disclosures might help plan participants.** Here are the hospital disclosures currently required, which must be updated annually:
  - **Consumer-friendly disclosure.** Hospitals must provide payer-specific negotiated charges, discounted cash prices, and deidentified minimum and maximum negotiated charges — the lowest and highest negotiated average price at the hospital — for 300 shoppable services. This information must be displayed and packaged in a "consumer-friendly" manner — for example, by using a price-estimator tool. Of the 300 shoppable services, CMS selected 70, and hospitals could choose the remainder.
  - **Publicly available, MRFs.** Each hospital must make available to the public MRFs that contain gross charges, payer-specific negotiated charges, discounted cash prices, and deidentified minimum and maximum negotiated charges for each item and service the hospital provides. The payer-specific negotiated charge is the charge for an item or service that a hospital has negotiated with an insurer or a TPA — or in some cases, directly with a plan or a plan sponsor.

Explore new opportunities to negotiate or directly contract rates with individual hospitals or hospital systems if a particular plan currently pays higher rates than what other entities pay. The hospital data and the MRFs should provide unprecedented insights into the rates that participants and plans pay for medical services and items like prescription drugs at hospitals. Be on the lookout for third-party analyses of the pricing data, and ask your vendors/insurers how they are analyzing the data.

- **Review newly released data, including new government reports, when available.** Providers and PBMs generally have treated negotiated rates as proprietary information inaccessible to plan sponsors. The transparency rule and the RxDC reporting requirement could infuse more competition into the healthcare marketplace, allowing plan sponsors to negotiate better rates while giving participants upfront estimates of medical expenses at different providers.

- **Look for more robust disclosures from hospitals as enforcement efforts increase.** Not all hospitals have fully complied with the transparency rule, but that may change as CMS increases enforcement. Effective Jan. 1, 2022, CMS increased the penalties for noncompliance (currently $300 per day) to a maximum total penalty of about $2 million per year. Besides sending out numerous warning and corrective letters, CMS has apparently taken two civil enforcement actions against hospitals that failed to comply with the rule.

Related resources

Section 3

Mental health parity

Action

Continue to comply with the MHPAEA. Ensure that the plan has a written comparative analysis of all NQTLs, as required by the 2021 CAA. Review the plan for NQTLs that have triggered litigation and agency scrutiny. Include assistance with NQTL comparative analyses in RFPs and vendor contracts. In 2023, watch for new legislation, guidance and the agencies' report to Congress, as well as ongoing and emerging parity and behavioral health coverage litigation. Consider MHPAEA parity requirements when improving a group health plan's medical or surgical benefits.

Specific steps

Continue to comply with MHPAEA. MHPAEA applies to grandfathered and nongrandfathered insured and self-insured group health plans sponsored by private-sector and state or local government employers that offer benefits for mental health and substance use disorder (MH/SUD) treatments. The act does not apply to retiree-only plans, excepted-benefit plans, self-insured nonfederal government plans that have opted out of MHPAEA or plans that don't provide MH/SUD benefits.

- Ensure covered MH/SUD benefits are in parity with covered medical/surgical benefits.
- Confirm plan terms and operations don't impose financial requirements or treatment limitations (quantitative and nonquantitative) on MH/SUD benefits that are more restrictive than those imposed on the same classification of medical/surgical benefits.
- Confirm the plan has completed a written NQTL comparative analysis that complies with the 2021 CAA.
  - Review the nine data elements required for each NQTL in FAQ 2 of the MH/SUD implementation and 2021 CAA FAQs Part 45.
  - Consider having in-house or outside counsel confirm compliance.
- Develop a response plan in case a government agency or a plan participant or representative requests the NQTL comparative analysis. Identify legal counsel to assist.
  - Plans risk potential penalties of up to $100 per day for failure to provide an NQTL within 30 days of a participant's request. Failure to respond could also trigger a DOL audit based on a participant complaint.
  - The window for initial response to a DOL request is generally short. Group health plans have 45 days to specify corrective actions if DOL finds a parity violation and only seven days to notify all enrollees of a final determination of noncompliance.

Verify that the carrier for an insured plan has completed the analysis and will notify the employer if a federal or state authority finds a parity violation.

- Confirm that the insurer will respond to any requests for the NQTL comparative analysis, whether the request is from CMS, a state authority, or a plan participant, a beneficiary or an enrollee.
- Verify that the insurer complies with applicable state mental health parity laws, including any reporting requirements.

For a self-insured plan sponsor that has yet to complete an NQTL comparative analysis, prepare one as soon as possible with assistance from TPAs and PBMs.

- Ask for a list of nonstandard NQTLs applied to the employer's plan — that is, any nonnumerical limitations or exclusions of MH/SUD treatments in the customized plan design. Work with the TPA and other experts (e.g., legal counsel and clinical experts) to prepare a comparative analysis of nonstandard NQTLs.
- When a separate vendor administers behavioral health benefits, engage assistance (e.g., legal counsel and clinical experts) to demonstrate that the vendor applies NQTLs comparably to how the medical TPA applies NQTLs to medical/surgical benefits.

Focus on NQTLs that have triggered enforcement action and litigation. Identify the following NQTLs in your plan, and ensure that the plan's comparative analysis demonstrates that each NQTL on MH/SUD benefits is in parity or else remove the NQTL:

- The 14 NQTLs identified in the agencies' 2022 MHPAEA report to Congress as commonly causing problems
- Any NQTL on applied behavior analysis (ABA) therapy
  - A plan that covers ABA therapy but imposes NQTLs on the coverage (for example, by imposing medical-management techniques or age limits) should ensure that the NQTLs are comparable to and applied no more stringently than those applied to medical/surgical benefits.
  - Consider eliminating any ABA therapy exclusion. Employer plan sponsors that want to continue excluding coverage for ABA therapy should evaluate the compliance risks with legal counsel.
- Any NQTL on medication-assisted treatment (MAT) for opioid use disorder
  - Pay particular attention to NQTLs on MAT that DOL identified in 2016 guidance, 2019 guidance and the self-compliance tool.

Require RFPs and vendor contracts to include assistance with the NQTL comparative analysis.

- Consider negotiating performance guarantees related to MHPAEA compliance, such as a guarantee of timely responses to disclosure requests from agencies or participants or a guarantee to conduct periodic self-audits for MHPAEA compliance.

Consider whether the network of behavioral health providers is adequate. Network adequacy is a plan standard to which the parity rules apply.

- Look at using telehealth and covering out-of-network MH/SUD care at in-network rates to improve access and help achieve network adequacy.
- Avoid “phantom networks” by ensuring providers in the network directory are taking new patients.

Consider MHPAEA when expanding medical or surgical benefits. Ensure that improving a plan’s medical or surgical benefits doesn’t inadvertently result in MHPAEA noncompliance.

- Reducing cost sharing for medical/surgical benefits might cause a plan’s financial limits on MH/SUD benefits to fail MHPAEA testing.
- Removing NQTLs on medical/surgical benefits could cause NQTLs to be applied more stringently to MH/SUDs.

In late 2022 through 2023, watch for new legislation, guidance, and the agencies’ report to Congress, as well as ongoing and emerging parity and behavioral health coverage litigation.

- Proposed legislation includes a variety of mental health provisions relevant to employers — from imposing civil monetary penalties for MHPAEA violations to eliminating opt-outs for self-funded government plans. (For more on mental health parity legislation, see Congressional outlook.)
- DOL is expected to update the MHPAEA self-compliance tool, and oversight agencies (DOL, Treasury and HHS) are expected to issue final guidance and a report to Congress on MHPAEA enforcement efforts, as required by the 2021 CAA.
- Litigation against employer-sponsored health plans and TPAs is expected to continue, including the case of *Wit v. United Behavioral Health* (Nos. 20-17363, 21-15193, 20-17364 and 21-15194 (9th Cir. March 22, 2022)). The district court in that case ordered United Behavioral Health (UBH) to reprocess more than 67,000 denied MH/SUD claims, finding UBH improperly used overly restrictive internal guidelines. The 9th Circuit overturned the district court’s order, but a rehearing has been requested. If the 9th Circuit’s decision stands, it might reduce the risk of class actions demanding the reprocessing of denied behavioral health claims or individual lawsuits challenging a plan’s clinical guidelines.

Related resources

Section 4

COVID-19 pandemic winds down

Action

In anticipation of the COVID-19 PHE and NE ending in 2023, review group health plan terms for COVID-19-related coverage, including testing, vaccines and treatment. Review benefit terms or offerings made under temporary COVID-19 relief laws and guidance. When agency relief during the COVID-19 NE expires, confirm proper winding down of extended deadlines for claims and appeals, HIPAA special enrollment and COBRA elections and payments. Review federal, state and local COVID-19 guidance on employee health and safety, leave, and workplace nondiscrimination, and review related policies as many of these requirements expire. Monitor federal legislation that could extend COVID-19 testing requirements or telehealth flexibilities.

Specific steps

Review plan coverage of COVID-19 testing, vaccines and treatments, and consider what, if any, changes to make when the PHE and NE expire. Reevaluate telehealth offerings and applicable state insurance coverage requirements.

- **Review group health plan coverage of COVID-19 testing and determine if coverage terms will change when the PHE expires.** During the PHE, group health plans (including grandfathered plans) must cover COVID-19 testing and related services without any participant cost sharing, prior-authorization requirements or other medical-management standards whenever a licensed healthcare or otherwise authorized provider deems the testing medically appropriate. Plans must also cover home over-the-counter (OTC) COVID-19 diagnostic tests, without a healthcare provider's involvement.
  - Determine whether to continue COVID-19 testing coverage after the PHE expires, limit coverage to in-network providers, or apply cost sharing or medical-management standards. Weigh the cost savings of any coverage change against the benefits of maintaining a healthy workforce by identifying and isolating COVID-19 cases early and often. Plans may be interested in limiting no-cost coverage to in-network providers to avoid the high costs charged by some nonparticipating providers and laboratories.
    - The HHS secretary authorizes PHEs for 90-day periods, unless terminated earlier. First declared on Jan. 31, 2020, the COVID-19 PHE has been renewed repeatedly, most recently on Oct. 13, 2022. The secretary is expected to provide 60 days' notice prior to expiration of the COVID-19 PHE.
  - Monitor federal legislation that could extend COVID-19 testing coverage requirements for group health plans beyond the PHE. Legislation (HR 6851) proposed in early 2022 would extend this mandate through the end of 2023, regardless of the PHE.
  - Watch for guidance on predeductible HDHP coverage of COVID-19 testing (and treatments) without affecting a participant's eligibility for HSA contributions. IRS Notice 2020-15 makes such coverage permissible "until further guidance is issued." IRS could issue guidance winding down this flexibility for HDHPs after the PHE

expires. (For more on predeductible COVID-19 coverage in HDHPs, see HSA, HRA and FSA developments.)

- **Review group health plan coverage of COVID-19 vaccines, and determine whether to change coverage terms when the PHE expires.** During the PHE, nongrandfathered group health plans must cover without cost sharing COVID-19 vaccines (all necessary doses and boosters, including administration) and related preventive services from both in-network and out-of-network providers.
  - Determine whether to continue covering COVID-19 vaccines and related services from out-of-network providers or limit this coverage to in-network providers after the PHE expires. When the PHE expires, the ACA preventive care mandate requires nongrandfathered group health plans to continue no-cost coverage of COVID-19 vaccines from in-network providers, but not from for out-of-network providers. (For more on preventive care requirements, see Preventive services.)
- **Review group health plan coverage of COVID-19 treatments, and determine whether to change coverage terms.** No federal law requires covering COVID-19 treatments without cost sharing, but some plan sponsors have chosen to provide generous coverage during the pandemic.
  - For plans still covering COVID-19 treatments with no or reduced cost sharing, determine whether to continue that coverage, and coordinate any change with the plan's insurer or stop-loss carrier.
  - For HDHPs covering COVID-19 treatments on a predeductible basis, watch for guidance winding down this flexibility after the PHE expires. (For more on predeductible COVID-19 coverage in HDHPs, see HSA, HRA and FSA developments.)
- **Review whether expanded telehealth benefits have to wind down.**
  - When the PHE expires, coverage of stand-alone telehealth programs will have to terminate at the end of the plan year, absent new regulatory guidance or congressional intervention. Temporary relief from many ACA group market reforms allowed large employers to offer stand-alone telehealth programs to employees ineligible for any other employer group health plan during the PHE.
  - Review telehealth plan coordination with HDHPs. Temporary relief allows (i) HSA-qualifying HDHPs to cover telehealth and other remote care services on a predeductible basis, and (ii) an otherwise HSA-eligible individual to receive predeductible coverage for telehealth and other remote care services from a stand-alone vendor outside of the HDHP, both without jeopardizing an individual's eligibility to make or receive HSA contributions. This telehealth flexibility for HDHPs extends only until Dec. 31, 2022. After that date, HDHPs that cover telehealth services on a predeductible basis will not be HSA-compatible so individuals receiving predeductible telehealth will not be able to make or receive HSA contributions, unless Congress temporarily or permanently extends this flexibility.
  - If necessary, prepare amendments to plan documents, and revise employee communications accordingly. (For more details, see HSA, HRA and FSA developments.)

- **If an insured plan sponsor, consult with carrier to confirm compliance with applicable state COVID-19 coverage requirements.** For insured plans, state laws may impose coverage requirements for COVID-19 testing, vaccines and treatment that go beyond the federal requirements. Essential health benefits (EHBs) generally include coverage for which treat COVID-19 diagnosis, treatment and vaccines.
  - For example, California law (2022 Ch. 545, SB 1473) extends required COVID-19-related coverage for insured plans and healthcare service plans (including HMOs) six months after expiration of the federal COVID-19 PHE. (For more on this topic, see these reports from The Commonwealth Fund and Kaiser Family Foundation (KFF).)

Determine whether to make plan changes midyear or at year-end.

- Consider the timing of any plan changes to COVID-19 testing, treatment or vaccination coverage. Waiting until the beginning of the next plan year may make sense; otherwise, prepare for the possibility of midyear election changes triggered by midyear plan coverage changes. Amend plan terms, ensure vendors will administer the plan accordingly, and prepare participant communications.
- If coverage terms will change after the PHE expires, prepare communications to distribute at least 60 days before the change, unless earlier communications indicated the general duration of the additional covered services and reduced cost sharing.
- If coverage enhancements will continue beyond the PHE, amend plan documents, and communicate changes to employees as necessary (e.g., through the SBC, SPD or summary of material modifications (SMM)).

Prepare to update plan administrative processes, including the deadlines for COBRA elections and premium payments, HIPAA special enrollment elections, benefit claims and appeals, and plan notices and disclosures.

- Prepare for the end of outbreak period relief that gives plan participants and COBRA qualified beneficiaries extended time to complete certain tasks, such as electing HIPAA special enrollment or COBRA coverage, paying COBRA premiums, and filing benefit claims or appeals.
  - These deadlines are paused until the earlier of (i) one year from the date a particular individual was first eligible for relief or (ii) 60 days from the end of the COVID-19 NE (i.e., the end of the outbreak period). The COVID-19 NE is expected to expire at the end of February 2023, unless the president extends it for another year.
  - Determine whether any previous communications about deadlines need adjustment when the NE expires. Decide whether, when and how to provide plan participants, COBRA qualified beneficiaries and others notices identifying deadlines that mark the end of each individual's truncated relief period.
- Prepare for the end of similar outbreak period relief that applies to distribution deadlines for nearly all ERISA plan notices and disclosures. When the outbreak period concludes, plans can't take advantage of relaxed rules allowing for electronic distribution of these required notices and disclosures during the outbreak period.
  - Check with insurers and plan administrators to see whether ERISA-required notices and disclosures are being distributed pursuant to temporarily relaxed rules. Confer

with the plan's insurer or administrator about winding down these temporary provisions and processes when the NE expires.

  - Resume normal distribution methods and timelines for providing ERISA notices and disclosures after the outbreak period ends. Limit electronic distributions to circumstances that satisfy DOL's electronic safe harbor rules.

- Confirm COBRA election notices continue to be provided in a timely manner, despite the relief allowing plans extra time to distribute notices. Delays in distributing COBRA election notices may further extend the election period, complicating administration even more.

- Watch for additional agency guidance or clarifications, particularly on the operation of relief periods when the NE ends.

Regularly review federal, state and local workplace safety, nondiscrimination and health guidance, and consult experts as needed.

- Monitor the CDC COVID-19 webpage, which tracks community spread and provides guidance for testing, vaccines, travel, and health and safety information for businesses and workplaces.

- Regularly check the Occupational Health and Safety Administration (OSHA) COVID-19 webpage, which includes FAQs and guidance on mitigating and preventing the spread of COVID-19 in the workplace, among other resources.

- Keep up with state OSHA standards, which may differ from federal standards and impose heightened employer requirements that may continue into 2023.

- Review federal, state and local guidance on workplace nondiscrimination issues related to COVID-19.

  - The Equal Employment Opportunity Commission (EEOC) enforces several federal laws on workplace nondiscrimination and regularly updates guidance related to COVID-19.

- Track state actions on COVID-19 vaccine mandates in the workplace (see this National Academy for State Health Policy report).

Consider offering updated COVID-19 booster shots (some of which may be bivalent and cover different strains) and flu shots through an on-site clinic or an excepted-benefit employee assistance program (EAP_.

- Keep in mind that on-site clinics and most EAPs are excepted benefits exempt from many of the ACA's ERISA group health plan requirements. Guidance from early 2021 confirms that both on-site clinics and excepted-benefit EAPs can offer COVID-19 vaccinations without jeopardizing excepted-benefit status. This guidance is not contingent on the PHE or NE.

- If, however, an EAP provides COVID-19 testing after the end of the PHE and NE, evaluate whether doing so provides "significant benefits in the nature of medical care" that would imperil excepted-benefit status.

Review federal, state and local guidance on COVID-19 leave and other leave laws, including sick leave, vaccine-related time off, leave to care for a family member or quarantine leave.

- Review federal guidance for employers and employees on pandemic-related issues from DOL's coronavirus resources website.
- Monitor state and local leave guidance, using references like Mercer's regularly updated GRIST, States, cities tackle COVID-19 paid leave. Although many COVID-19 paid leave mandates have expired, a few remain in effect, and other jurisdictions have created new leave requirements that could be triggered by future PHEs.

Related resources

Section 5

Gender and family planning issues in benefits

Action

Assess the health plan impact of the Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision. Employers considering enhanced fertility, adoption and surrogacy benefit programs to support DEI goals and the needs of a diverse workforce should be mindful of compliance issues, including federal tax law, the ACA and state laws. Review contraceptive coverage to confirm compliance with recent agency guidance. Consider whether federal or state laws require benefit changes for LBGTQ employees and their family members.

Specific steps

Assess the group health plan implications of the Supreme Court's *Dobbs v. Jackson Women's Health Organization* decision (141 S. Ct 2228 (2022)), overturning *Roe v. Wade* and permitting states to regulate abortion at all stages of pregnancy.

- Review current abortion coverage under medical and pharmacy plans and determine what, if any, changes will be made to your benefit plans or programs.
  - Check with insurer or TPA regarding the coverage and availability of medication abortions and access to prescriptions via mail in accordance with FDA guidelines.
  - If adding or enhancing a travel and lodging benefit, consult with counsel about compliance considerations, such as coverage and reimbursement limitations under ERISA and the tax code, mental health parity and nonquantitative treatment limits, and privacy protections.
  - Explore telemedicine, healthcare navigation assistance (e.g., logistical support finding a provider and understanding plan coverage) and concierge services (e.g., booking appointments, travel and lodging options, or general member support), and review leave policies if seeking to support employees needing abortion care.
  - Consult with counsel about current and future legal risks associated with state regulation of abortion. Discuss the extent to which a plan sponsor can rely on ERISA preemption as a defense to state laws or enforcement activity. Stay apprised of emerging state legislation and court challenges.
- Confirm with medical and pharmacy vendors that plan participants can access legally prescribed and clinically appropriate medications (e.g., drugs used for arthritis, ulcers, miscarriages, and Crohn's disease that are also used for abortions) without interference from pharmacists and pharmacies concerned about legal liabilities in states with abortion restrictions.

- Monitor the potential impact on employee health benefit plans from federal agencies' responses to the president's July 8 and Aug. 3 executive orders to protect access to reproductive healthcare services.

  – Review HHS's HIPAA privacy rule and disclosures of information relating to reproductive healthcare. Discuss with counsel the potential privacy issues related to abortion coverage and the group health plan.

  – Review HHS guidance if offering any mobile health apps to employees, whether connected to or separate from the group health plan.

Consider expanding fertility coverage to individuals without a traditional infertility diagnosis. As part of DEI efforts, many employers are expanding fertility coverage to employees, regardless of their marital status, gender or sexual orientation. In addition, participants in the past year have brought discrimination claims against employer plans and student health plans requiring a traditional infertility diagnosis to access fertility benefits.

- Work with legal counsel, tax advisors and vendors to determine whether and how to tax employees for fertility benefits. Fertility benefits can be excluded from an employee's taxable income only if considered medical care. IRS hasn't issued guidance addressing when fertility treatments are medical care, but an IRS private letter ruling (PLR) allowed the deduction for sperm donation and freezing costs directly attributable to the taxpayer. The few reported cases — involving male taxpayers trying to conceive — have found expenses related to egg donation, *in vitro* fertilization (IVF) and freezing are not tax-deductible.

- Consult a tax advisor if adding coverage for the storage of eggs, sperm or embryos. Even for employees with an infertility diagnosis, IRS Publication 502 indicates that "temporary" storage is tax-preferred, but IRS does not identify the point at which storage costs become taxable.

- Ensure compliance with the ACA's ban on annual or lifetime dollar limits for EHBs. Self-insured plan sponsors should remove dollar limits on fertility benefits or confirm that fertility benefits aren't considered EHBs under the selected state benchmark plan. Consider cycle limits as an alternative.

- Limit fertility benefits to group health plan enrollees, or discuss the risks of a stand-alone fertility benefit program with counsel. A stand-alone fertility benefit program is a group health plan that would likely violate ACA mandates (for example, by not covering preventive services without cost sharing).

- Ensure that any fertility point-solution complies with transparency requirements, to the extent applicable.

  – Determine whether and how the vendor will provide in-network rates and out-of-network allowed amounts/billed charges for expanded fertility coverage and ensure that such information is posted in machine-readable files (MRFs). (For more information on the need for MRFs, see Group health plan transparency.)

  – Determine whether and how to report the fertility vendor's prescription drug and healthcare spending information by Dec. 27, 2022 (and annually by June 1

thereafter). (For more information on this reporting requirement, see Prescription drugs.)

- Consider HSA/HRA issues.
  - Ensure that fertility coverage doesn't cause an individual to lose eligibility to make or receive contributions to an HSA. For example, an HRA that pays for fertility treatments before an individual reaches the HDHP deductible would be HSA-disqualifying coverage.
  - In addition, an HRA should only reimburse fertility expenses that are medical care as defined by the Internal Revenue Code, which can be difficult to determine.

Review access to certain fertility services, such as IVF, in light of state abortion bans and emerging fetal personhood legislation. For example, abortion bans that start at conception and fetal personhood laws could create liabilities for disposing any fresh or frozen embryos.

Work with counsel to ensure proper tax treatment of the surrogacy benefit program and to consider ERISA compliance issues.

- Favorable tax treatment may be available for a limited set of surrogacy expenses — namely, medical expenses for an employee or an employee's spouse diagnosed as infertile. Other surrogacy benefits are taxable income.
- Reimbursing a surrogate's medical expenses could create a noncompliant ERISA group health plan, as well as rights that the surrogate could enforce against the plan. Consider limiting reimbursements to taxable nonmedical expenses (e.g., legal and agency fees).

Check for any international or state laws impacting fertility, adoption, or surrogacy benefits. For example, reimbursement of egg freezing or surrogacy expenses could violate some international or state laws. Obtain the services of legal counsel or a vendor to assist with tracking relevant laws and determining whether particular expense reimbursements violate international or state law.

Review compliance considerations for adoption benefit programs.

- Confirm that any tax-advantaged adoption benefit complies with IRC Section 137 requirements. For 2023, up to $15,950 (less for high-income employees) of qualifying adoption expenses per eligible child may be excluded from an employee's income, if those expenses are paid by an adoption assistance program that satisfies Section 137. Program requirements include a written plan document, employee notice and compliance with nondiscrimination rules. Section 137 does not permit reimbursements to pay for surrogacy arrangements, adoption of a stepchild, or expenses in violation of a state or federal law.
  - If providing adoption benefits beyond what Section 137 permits, work with a tax advisor to make sure that employees are taxed appropriately.

Consult with counsel to ensure proper administration of benefits offered on an after-tax basis (e.g., travel and lodging, fertility, adoption, or surrogacy benefits).

- Determine whether such expenses are deductible.

- Consider whether taxable reimbursements increase hourly wages for overtime, vacation and other employment-related purposes.

- Decide whether to "gross up" employees for withheld taxes and how to ensure compliance with deferred compensation rules and the constructive receipt doctrine.

- Determine how to handle sensitive information, given that HIPAA would presumably not apply to a post-tax (i.e., non-health) benefit program.

Review contraceptive coverage in any nongrandfathered health plan to ensure compliance with the ACA's preventive services mandate. In 2022, the agencies renewed their focus on ACA-mandated contraceptive coverage, issuing January and July FAQs, as well as a June 27 letter to plan sponsors and insurers. (For more details on this ACA mandate, see Preventive services.)

Review transgender coverage, and analyze whether limits or exclusions on transgender benefits violate Title VII of the 1964 Civil Rights Act (Title VII), ACA Section 1557, MHPAEA, the Americans with Disabilities Act (ADA) or any state law.

- Review the increasing number of successful court challenges under Title VII against plans with limited transgender coverage (for example, an exclusion of mastectomies for gender dysphoria).

- Consider whether ACA Section 1557's ban on sex discrimination requires offering or expanding transgender coverage. Since 2016, regulations and litigation have shaped (and reshaped) the scope of Section 1557. Few group health plans are currently subject to Section 1557, but proposed rules, if finalized, would touch many more employer-sponsored health plans. Under the proposed rules, Section 1557 would apply to *all* operations of any health insurer or TPA that receives HHS funds and would include protections for gender-affirming care.

- Review any exclusions or limits on the plan's coverage of gender dysphoria treatment and services (including gender affirmation surgery) for compliance with MHPAEA and any applicable state parity laws. Exclusions of transgender services regardless of medical necessity are NQTLs on a mental health condition that should be analyzed for parity with medical/surgical benefits. (For more information, see Mental health parity).

- Review any exclusions or limits on the plan's coverage of gender dysphoria treatment and services for ADA compliance. A recent opinion by the 4th US Circuit Court of Appeals held for the first time that gender dysphoria can be a disability entitled to ADA protections (*Williams v. Kincaid,* No. 21-2030 (4th Cir. Aug. 16, 2022)). The ADA considers group health plan limits or exclusions to be disability-based if they disadvantage only — or almost only — employees with disabilities.

- Compare health plan coverage of gender dysphoria against the recently released version 8 of the World Professional Association for Transgender Health (WPATH) guidelines.

For churches and employers with religious objections to covering same-sex spouses or transgender services, consult legal counsel about the risks of these exclusions and potential exemptions. Monitor regulatory developments and legal challenges.

- A recently proposed Section 1557 rule would, if finalized, permit recipients of HHS financial assistance to raise conscience and religious freedom objections with HHS's

Office of Civil Rights, which must promptly consider the objection and stay enforcement efforts during such consideration.

- At least one court has rejected arguments that a religious organization should be exempt from Title VII and ruled in favor of an employee challenging an exclusion of same-sex spouses. However, another court has prohibited HHS from enforcing Section 1557's ban on discrimination against a religious organization that excluded transgender and abortion coverage from its group health plan.

Related resources

Section 6
Surprise billing

Action

Confirm plan administrators are complying with the ban on surprise billing for emergency services, air ambulances and certain nonemergency services covered by the NSA. Verify that emergency services are covered to the extent required by the NSA, and plan documents have corresponding updates. Make sure plan documents also contain the necessary cost-sharing information for all services protected by the NSA. Confirm the latest required surprise billing notice is posted on a public website and included with EOBs. Review IDR frequency and outcomes. Consider the appropriateness of additional vendor fees related to surprise billing compliance and/or any shared-savings program charges.

Specific steps

Confirm plan administrators are properly identifying and adjudicating claims subject to the NSA. The NSA's surprise billing protections against out-of-network cost sharing and provider balance-billing apply to claims for (i) emergency care (including ancillary services) received at an out-of-network facility or at an in-network facility from an out-of-network provider; (ii) out-of-network nonemergency services at an in-network healthcare facility (unless written consent obtained); and (iii) air ambulance services from out-of-network providers.

- Determine which plans are subject to the surprise billing rules.
  - The rules apply broadly to grandfathered and nongrandfathered group health plans, as well as federal and nonfederal governmental plans, certain church plans, so-called "grandmothered" or transitional plans, and individual policies (including student health insurance).
  - The rules don't apply to excepted benefits, retiree-only plans, short-term limited-duration insurance, or HRAs and other account-based plans.
- Confirm that plan administrators are calculating cost-sharing amounts for these protected services in compliance with the law and rules.
  - Plan participants cannot be charged more than they would be for in-network services, even if the plan has no out-of-network coverage.
  - Cost sharing is typically based on the qualifying payment amount (QPA), which is generally the plan's or issuer's median contracted rate as of Jan. 1, 2019, adjusted for inflation.
  - Plans with no network and no median contracted rate (e.g., reference-based pricing plans) generally must use an eligible database to determine the QPA for emergency services and air ambulance services.

    - The NSA's surprise billing protections do not apply to out-of-network nonemergency services provided at a participating healthcare facility when the plan doesn't have a network of participating healthcare facilities.
  - The cost-sharing amount must count toward any in-network deductible or out-of-pocket maximum.

Confirm plan administrators are timely providing the initial payment (or a denial notice) with required disclosures to nonparticipating providers. Plans have only 30 calendar days to send the initial payment with required disclosures or a denial notice.

- The 30-day period begins when the plan receives a "clean claim," which is the information necessary to adjudicate the claim.
- The initial payment should be the payment in full based on relevant facts and circumstances and plan terms; it doesn't have to be equivalent to the QPA.
- When cost sharing is based on the QPA, the initial payment (or denial notice) must include:
  - The QPA for each item or service
  - A certification that the QPA applies when determining cost sharing
  - A statement about the opportunity for a 30-day negotiation period, followed by IDR to determine the total payment, if necessary
  - Contact information to initiate a negotiation period
- If the service codes or modifiers on the claim change and result in a lower reimbursement (i.e., down-coding), additional disclosures must accompany the initial payment:
  - A statement indicating whether the QPA is based on the down-coded service code or modifier
  - An explanation and a description of the codes and modifiers adjusted
  - The QPA without the down-coding
- Confirm that when payment is denied, plan administrators are including an explanation with the denial notice.
- Verify that plan administrators are accepting the standard open-negotiation notice from out-of-network providers and facilities. Plan administrators may encourage the use of an online portal for submission of necessary or supplementary information but cannot require this to initiate the negotiation period.

Confirm emergency services are covered to the extent required by the NSA, and review plan documents (including SPDs and SBCs) for coverage terms. If any emergency services are covered, both grandfathered and nongrandfathered plans must cover all emergency services and comply with surprise billing protections. The NSA defines emergency services to include items and services needed to screen, treat and stabilize someone with an emergency medical condition, including routine ancillary services needed for evaluation and post-stabilization items and services (which include outpatient observation or inpatient/outpatient stay when provided with the emergency services). Services provided

in hospital emergency departments and independent free-standing emergency centers are included, as are services provided in urgent care centers and behavioral health crisis facilities that are licensed by the state to provide emergency services for an emergency medical condition.

- Verify that coverage is not limited by plan terms or conditions (other than a coordination-of-benefits provision, a permissible waiting period or cost-sharing requirements). Make sure out-of-network providers aren't subject to administrative requirements or benefit limitations more restrictive than those applied to in-network emergency service providers.
- Confirm coverage of post-stabilization services as emergency services, unless the member consents to the out-of-network care and agrees to balance billing after proper notice, among other requirements.
- Confirm coverage of emergency services without prior authorization for both in-network and out-of-network providers and facilities.

Make sure plan administrators are making external reviews available for NSA compliance matters. The ACA's external review requirement for adverse benefit determinations now applies to all NSA-protected claims, including those handled by grandfathered plans otherwise exempt from this ACA requirement.

- Adverse benefit determinations related to NSA compliance include the cost-sharing and surprise billing protections for emergency services and care provided by nonparticipating providers at participating facilities, as well as the requirement that claim coding accurately and correctly reflects treatments received and the associated NSA protections.

Confirm the latest required surprise billing notice is posted on a public website and included with EOBs. The notice must use plain language and contain information about balance-billing restrictions, applicable state and federal protections, and contact information for an appropriate state and federal agency in the event a provider or facility violates the balance-billing restrictions.

- Confirm the revised model notice (version 2) is used for plan and policy years beginning on or after Jan. 1, 2023, for good-faith compliance with the disclosure requirement.
- If the plan doesn't have a public website, make sure a written agreement is in place with the TPA to post the notice on the public website where the TPA normally makes information available to participants, beneficiaries and enrollees on the plan's behalf. Verify that the notice does appear on the TPA's public website.
- Make sure the notice contains information on applicable state laws; however, information on all state balance-billing laws is not required.

Review IDR frequency and outcomes, and consider the appropriateness of additional vendor fees related to surprise billing compliance and/or any shared-savings program charges.

- Consider including performance guarantees related to compliance with the surprise billing law and rules insurer policies and TPA contracts. Weigh whether to include performance guarantees related to IDR frequency and outcomes.
  - Agencies report an unexpectedly high volume of IDR claims. As of Aug. 11, 2022, more than 46,000 disputes were initiated, with payment determination rendered in

over 1,200. In nearly half of all disputes, the noninitiating party argued that the dispute was ineligible for IDR, and over 7,000 have been found to be ineligible.

Watch for additional regulations and agency guidance on the NSA's surprise billing provisions.

- Ongoing litigation challenging parts of the NSA's implementing regulations could force more changes.
  - Final regulations issued in August 2022 revise certain aspects of interim final regulations issued in July and October 2021 to reflect comments received and the outcome of earlier litigation.
  - New cases are challenging portions of the final regulations, while some challenges to the interim final rules are ongoing.
- To determine the need for additional guidance, agencies continue to collect comments, monitor plans' and issuers' compliance with the NSA implementing regulations, and evaluate how parties to a payment dispute interact during the open-negotiation period.

Related resources

Section 7

State-mandated paid leave and other state law trends

Action

Track state legislation and regulations affecting benefits, including paid leave requirements, health plan reporting obligations, PBM restrictions (see Prescription drugs for more details) and telehealth mandates. Work with insurers and vendors to ensure compliance with new coverage mandates, and evaluate cost increases. Monitor ERISA preemption litigation that may impact state laws affecting employee benefit plans.

Specific steps

Evaluate current PFML, accrued paid sick leave, and other leave benefits against relevant state and local mandates, and revise plans as needed.

- **Review general leave strategy.** If operating in multiple states, consider developing a long-term strategy to provide PFML and sick leave parity across jurisdictions that have widely differing benefit amounts, accruals and eligibility rules. In particular, a number of state laws define "family member" more broadly than the federal Family and Medical Leave Act (FMLA) to include any designated person in the equivalent of a family relationship.

- **Monitor PFML guidance in states with new laws.** Watch for regulations and rules in states where benefits and/or contributions have not yet begun: Colorado, Delaware, Maryland and Oregon.

- **Check for PFML guidance in jurisdictions with revised requirements.** Address what, if any, modifications will be needed to comply with expanded requirements in Connecticut, Massachusetts and Washington, DC.

- **Adjust for PFML rate changes.** Adjust systems and payroll deductions as needed to accommodate changes in PFML rates for 2023.

- **Track states considering PFML programs.** Keep track of states that may add PFML insurance programs, including Hawaii, Illinois, Louisiana, Maine, Minnesota, Vermont, Virginia and Wisconsin.

- **Monitor local paid sick leave mandates.** Stay abreast of local jurisdictions (like Bloomington, MN, and West Hollywood, CA) that adopt paid sick leave requirements. Other localities may follow the example of San Francisco, where voters approved Proposition G, which mandates up PHE leave in certain circumstances.

- **Keep tabs on litigation involving Michigan's paid sick leave law.** Monitor developments related to Michigan's paid sick leave law. A recent state court decision (currently stayed) would change accrued benefits and annual benefit caps, as well as

eliminate a small employer exception for employers with fewer than 50 employees (*Mothering Justice v. Nessel*, No. 21-000095-MM (MI Cl. Ct. July 19, 2022)).

- **Track bereavement leave laws.** Watch for additional states to follow the lead of Illinois and California in adopting bereavement leave laws that go beyond an employer's traditional program or policy.

Review processes for complying with group health plan reporting obligations and assessments, and new long-term care (LTC) requirements.

- **Complete individual mandate reporting.** California, Massachusetts, New Jersey, Rhode Island, Vermont and Washington, DC, require group health plan reporting. Massachusetts has two requirements: the Health Insurance Responsibility Disclosure (due Nov. 15) and Form MA 1099-HC (due Jan. 31). State time frames for individual mandate reporting typically (but not always) match ACA deadlines. Submission of Form 1095-C usually (but not always) will suffice. Stay abreast of changes from prior years.
- **Comply with group health plan assessments and reporting.** Ensure ongoing compliance with group health plan assessments in New York (Health Care Reform Act Covered Lives Assessment (CLA)), Washington (Partnership Access Lines CLA), and San Francisco (Health Care Security Ordinance Annual Reporting Form and the Health Care Accountability Ordinance (applicable to city and county contractors)).
- **Prepare for Washington's LTC law.** Washington's LTC law (WA Rev. Code Ch. 50B.04, as amended by two later laws: 2022 Ch. 1, HB 1732 and 2022 Ch. 2, HB 1733) requires employee contributions via payroll deduction, starting July 1, 2023. Exemptions are available to employees who want to avoid these contributions. Payments and quarterly reports are due to the Employment Security Department by the last day of the month after each calendar quarter ends.

As states address telehealth access, consider expanding telehealth benefits, especially for behavioral health.

- **Track states joining behavioral health compact.** Use of telehealth for mental healthcare may increase since more than half of all states participate in the Psychology Interjurisdictional Compact (PSYPACT), an initiative that facilitates cross-state practice of telepsychology and temporary in-person, face-to-face psychology.
- **Watch for post-COVID-19 telehealth contraction.** Stay abreast of state legislative and regulatory efforts to undo telehealth gains made during the COVID-19 pandemic. These developments will likely center on fully insured plans but could impact the general practice of medicine within a state, which would affect self-funded plans. Issues include interstate licensure, the ability to prescribe medications, requirements for "hot handoffs" to an in-person provider and the circumstances that establish a provider-patient relationship.

Confirm with insurers how state coverage mandates affect fully insured coverage.

- **Review the potential impact on premium rates.** Discuss the premium cost impact (if any) of new coverage requirements, such as insulin cost-sharing caps (for example, in Louisiana, Maryland, Oklahoma, Oregon and Washington), fertility benefits, gender-affirming care, mental health parity changes, surprise billing, required testing, expanded eligibility, and other new or expanded health coverage mandates.

- **Consider extraterritorial issues.** Confirm the plan's state of issue (situs), and determine whether new insurance provisions apply on an extraterritorial basis and impact any insured plan covering employees in those states, even if the plan is situsued elsewhere. Abortion coverage and restrictions will almost certainly be touchstone issues as state laws develop in the post-*Dobbs* era.

Monitor federal court rulings that involve ERISA preemption.

- **Pay attention to ERISA-based challenges to state laws that extend to self-funded plans.** Recent court rulings on ERISA preemption challenges to PBM laws (see Prescription drugs) have upheld the state laws. New and recent abortion laws — if applied to group health plans — are likely to raise ERISA preemption issues. For example, ERISA generally preempts state civil remedies imposed against a plan sponsor but would not preempt state insurance laws or criminal statutes of general application.
- **Monitor pending US Supreme Court petitions.** Look for developments on ERISA preemption, particularly the ERISA Industry Committee (ERIC) litigation concerning ERISA's preemption of a Seattle healthcare ordinance for hotel industry employers.
  - The ordinance survived an ERISA preemption challenge in the 9th US Circuit Court of Appeals (*ERIC v. Seattle*, No. 20-35472 (9th Cir. March 17, 2021). A decision on ERIC's petition for writ of certiorari should occur in late 2022 or early 2023. If the Supreme Court takes up the case, a decision might be issued by July 2023. A win for Seattle might encourage other similar state and local mandates, a concern for employers with fully insured and self-funded plans.
  - Another pending petition involves life insurance proceeds (*Ragan v. Ragan*, No. 21-1571 (CO App. Feb. 14, 2022)). Relying on 9th Circuit precedent, Colorado's Court of Appeals held that ERISA preempts a post-distribution claim for life insurance proceeds under the state's domestic relations law. Other federal appeals courts to address the issue have found that ERISA does not preempt claims brought under state laws challenging distribution of ERISA plan proceeds.

Related resources

Section 8

Preventive services

Action

Confirm nongrandfathered group health plans cover all ACA-required in-network preventive services without cost sharing. Modify 2023 benefits for the latest ACA guidance and any new or updated USPSTF, HRSA and ACIP recommendations, including coverage of "qualifying coronavirus preventive services." Determine the starting age for mandated coverage of breast cancer screening without cost sharing. Ensure coverage of all ACA-mandated women's contraceptives, unless the employer has religious or moral objections to contraceptives. Monitor litigation that could spare employer plan sponsors with religious objections from covering PrEP HIV medications and all nongrandfathered group health plans and insurers from covering ACA-mandated USPSTF-recommended preventive services without cost sharing (*Braidwood Mgmt. Inc. v. Becerra*, No. 4:20-cv-00283-O (ND TX Sept. 7, 2022)). Track litigation that could require group health plans and insurers to continue covering instruction in fertility awareness-based methods (*Tice-Harouff v. Johnson*, No. 6:22-cv-201-JDK (ED TX Aug. 12 2022)). Update official plan documents, SPDs, SBCs and other materials as needed.

Specific steps

Update a nongrandfathered group health plan's preventive services covered without cost sharing for the latest ACA guidance and any new or revised USPSTF, HRSA and ACIP recommendations.

- Coverage generally must conform for plan years that begin on or after the one-year anniversary of the date when a preventive care recommendation or guideline was issued or updated. However, group health plans must cover new COVID-19 vaccines and other preventive items or services within 15 business days after an ACIP recommendation or a USPSTF A or a B recommendation. October 2021 FAQ guidance clarified that the 15 business days is measured from Dec. 12, 2020, the date the CDC adopted the ACIP's recommended use of particular COVID-19 vaccines within the scope of the emergency use authorization (EUA) or the biologics license application (BLA). As a result, effective Jan. 5, 2021, group health plans must "immediately" cover any new COVID-19 vaccine once authorized under an EUA or approved under a BLA by the FDA.
- A USPSTF recommendation or guideline is considered to be issued on the last day of the month when released or published. The issuance date of an ACIP recommendation or guideline is considered to occur when adopted by the CDC director. An HRSA recommendation or guideline is deemed to be issued once accepted by the HRSA administrator or, if applicable, adopted by the HHS secretary.

Review group health plan coverage of COVID-19 testing and vaccines, and determine if coverage will change when the PHE expires.

- **COVID-19 tests and related services.** During the PHE, all group health plans, including grandfathered plans, must cover COVID-19 tests and related services without any

participant cost sharing, prior authorization, or other medical-management requirements whenever a licensed healthcare or otherwise authorized provider deems the testing medically appropriate. This coverage mandate includes home OTC COVID-19 diagnostic tests, and the participant cost-sharing ban extends to deductibles, copayments and coinsurance. The PHE, currently renewed through Jan. 10, 2023, is renewed in 90-day increments by the HHS secretary. (For more information, see COVID-19 pandemic winds down.)

  - In a letter to state governors in early 2021, then acting HHS Secretary Norris Cochran indicated that HHS will provide 60 days' advance notice of the PHE's expiration or termination. Current HHS Secretary Xavier Becerra has also committed to giving 60 days' advance notice to states and the healthcare community.
  - Group health plans should determine whether to continue COVID-19 diagnostic testing coverage after the PHE expires, limit coverage to in-network providers or apply cost sharing or other medical-management standards.

- **COVID-19 vaccines and administration costs.** Nongrandfathered group health plans must cover all COVID-19 vaccines and associated administration costs without any cost sharing (including deductibles, copayments and coinsurance) within 15 business days (excluding weekends and holidays). Coverage of a particular vaccine must be consistent with the scope of the EUA or BLA (including amendments) and allow for (i) administering an additional dose to certain individuals, (ii) administering booster doses, or (iii) expanding the age range of individuals for whom the vaccine is authorized or approved.
  - During the PHE, this cost-sharing ban also applies to *out-of-network* COVID-19 vaccines.
  - To promote workplace health and safety, grandfathered group health plans should consider covering these vaccines free of cost sharing as well.
  - All group health plans should determine whether to continue covering these vaccines and administration costs from out-of-network providers or limit the coverage to in-network providers after the PHE expires.

Add or update no-cost in-network coverage of preventive services with a USPSTF A or B recommendation issued in 2021 and effective Jan. 1, 2023, for calendar-year plans. For noncalendar-year plans, the effective date could be the plan year beginning in 2022 or 2023, depending on when the plan year starts relative to the date USPSTF issued the recommendation.

- **Tobacco use cessation behavioral interventions for all adults and pharmacotherapy for all nonpregnant adults.** Ask all adults — including pregnant persons — about tobacco use, advise them to stop using tobacco and provide behavioral interventions. Also provide nonpregnant adults FDA-approved pharmacotherapy for tobacco use cessation. This recommendation replaces one from 2015 by incorporating new evidence on the harms of e-cigarettes (i.e., vaping) and a description of the 2019 e-cigarette- or vaping-associated lung injury (EVALI) outbreak in the United States. USPSTF finds insufficient evidence about the benefits and harms of pharmacotherapy for pregnant persons and the use of e-cigarettes for tobacco cessation in all adults. USPSTF notes that clinicians should direct patients to other cessation interventions with proven effectiveness and safety. (Issued January 2021)

- **Lung cancer screening for adults ages 50–80 with a 20 pack-year smoking history — defined as 20 years of smoking at least 20 cigarettes (one pack) per day — who currently smoke or have quit within the past 15 years.** Screen for lung cancer with low-dose computed tomography (LDCT) in adults ages 50–80 years with a 20 pack-year smoking history who currently smoke or have quit within the past 15 years. Discontinue screening once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. This recommendation replaces one from 2013 by lowering the age range to 50 (from 55) and reducing the pack-year history to 20 (from 30). (Issued March 2021)
- **Hypertension screening for adults ages 18 or older.** Screen for hypertension in adults ages 18 or older with office blood pressure measurement (OBPM). USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment. This recommendation reaffirms one from 2015 but advises the use of OBPM for initial screening, updates language to reflect current evidence, and clarifies implementation strategies. (Issued April 2021)
- **Colorectal cancer screening for adults ages 45–75.** Screen for colorectal cancer in all adults ages 45–75. This recommendation replaces one from 2016 by lowering the recommended age range to 45 (from 50). (Issued May 2021)
  - FAQ guidance confirms that plans must cover without cost sharing a follow-up colonoscopy after a positive noninvasive stool-based or direct visualization screening test for colorectal cancer. The preliminary test does not convert the follow-up colonoscopy into a diagnostic test; the follow-up colonoscopy remains a preventive service.
- **Healthy weight and weight gain behavioral counseling for pregnant adolescents and adults.** Offer all pregnant adolescents and adults effective behavioral counseling to promote healthy weight gain and prevent excessive weight gain during pregnancy. This is a new recommendation. (Issued May 2021)
- **Gestational diabetes screening for asymptomatic pregnant persons at or after 24 weeks of gestation.** Screen for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or later. This recommendation is consistent with one from 2014. (Issued August 2021)
- **Prediabetes and type 2 diabetes screening for overweight or obese adults ages 35–70.** Screen for prediabetes and type 2 diabetes in overweight or obese adults ages 35–70 and offer or refer patients with prediabetes to effective preventive interventions. This recommendation replaces one from 2015 by lowering the recommended starting age to 35 (from 40). (Issued August 2021)
- **Chlamydia and gonorrhea screening for all sexually active women ages 24 or younger and women ages 25 or older with increased risk for infection.** Screen for chlamydia and gonorrhea in all sexually active women ages 24 or younger and in women 25 years or older with increased risk for infection. This recommendation is consistent with one from 2014. USPSTF finds insufficient evidence about the benefits and harms of screening for chlamydia and gonorrhea in men. (Issued September 2021)
- **Aspirin preventive medication after 12 weeks of gestation in persons at high risk for preeclampsia.** Prescribe low-dose (81 mg/day) aspirin as preventive medication after 12 weeks of gestation in persons at high risk for preeclampsia. This recommendation is

consistent with one from 2014 but strengthened by additional trials showing low-dose aspirin reduces the risks of perinatal mortality. (Issued September 2021)

- **Dental caries prevention for infants and children under age 5.** Primary care clinicians should (i) prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride and (ii) apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. This recommendation is consistent with one from 2014. USPSTF finds insufficient evidence about the benefits and harms of primary care clinicians performing routine screening for dental caries in children younger than age 5. (Issued December 2021)

Prepare to add or update no-cost in-network coverage of preventive services with a USPSTF A or B recommendation issued in 2022 and effective Jan. 1, 2024, for calendar-year plans. For noncalendar-year plans, the effective date could be the plan year beginning in 2023 or 2024, depending on when the plan year starts relative to the date USPSTF issues the recommendation.

- **Statin preventive medication for adults ages 40–75 who have at least one cardiovascular disease (CVD) risk factor and an estimated 10% or greater risk of experiencing a cardiovascular event in the next 10 years.** Prescribe a statin for the primary prevention of CVD for adults ages 40–75 who have one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension or smoking) and an estimated 10% or greater risk of experiencing a cardiovascular event over the next 10 years. This recommendation is consistent with one from 2016. USPSTF finds insufficient evidence on the benefits and harms of initiating a statin for primary prevention of CVD events and mortality in adults ages 76 or older. (Issued August 2022)

- **Syphilis infection screening for nonpregnant adolescents and adults.** Screen for syphilis infection in adolescents and adults who have ever been sexually active and are at increased risk infection. This recommendation reaffirms one from 2016. (Issued September 2022)

- **Depression and suicide risk screening for adolescents ages 12–18.** Screen for major depressive disorder (MDD) in adolescents ages 12–18 years. This recommendation replaces but is consistent with ones from 2014 on screening for suicide risk in adolescents and 2016 on screening for MDD in children and adolescents. USPSTF finds insufficient current evidence to assess the balance of benefits and harms of screening for MDD in children under age 11 and for suicide risk in children and adolescents. A separate review on screening for suicide risk in adults is currently in progress. (Issued October 2022)

- **Anxiety screening for children and adolescents ages 8–18.** Screen for anxiety in children and adolescents ages 8–18. This is a new recommendation. USPSTF finds insufficient current evidence to assess the balance of benefits and harms of screening for anxiety in children under age 8. (Issued October 2022)

- **Any additional preventive services recommended during 2022.** If additional preventive service recommendations come out in 2022 (after the date of this article), ensure noncalendar-year plans comply by the applicable 2023 or 2024 effective date and calendar-year plans comply by Jan. 1, 2024.

Determine the starting age for mandated coverage of breast cancer screening without cost sharing.

- Until Jan. 1, 2023, the 2021 CAA requires group health plans to follow the September 2002 USPSTF recommendation that requires no-cost screening mammography, with or without clinical breast examination, every one to two years for women beginning at age 40.
- The January 2016 USPSTF recommendation (which indicates an update is in progress) and the December 2009 USPSTF recommendation call for biennial screening mammography beginning at age 50. Both the 2009 and 2016 recommendations give the screening of women in their 40s a "C" rating and say the decision should be individualized.
- HRSA-supported women's preventive services guidelines continue to recommend "average-risk women initiate mammography screening no earlier than age 40 and no later than age 50," and then "at least biennially and as frequently as annually."
- What the starting age for biennial screening mammography will be beginning Jan. 1, 2023, is unclear. The 2016 recommendation presumably will go back into effect on Jan. 1, 2023.

Ensure coverage of new and updated HRSA-supported women's preventive services, effective for plan years beginning in 2023.

- In December 2021, HRSA added a new obesity-prevention guideline for midlife women. The agency also updated five existing women's preventive services guidelines: well-women preventive visits, breastfeeding services and supplies, counseling for sexually transmitted infections, screening for HIV infection, and contraception. (For related information, see Gender and family planning issues in benefits.)

Check ACIP's list of vaccines to determine whether the plan must add new vaccines to cover free of cost sharing.

Ensure continued coverage of ACA-mandated women's contraceptives approved by the FDA, unless the employer has religious or moral objections to contraceptives. (For related information, see Gender and family planning issues in benefits.)

- Continue to cover all FDA-approved women's contraceptives without cost sharing, unless declining or revoking this coverage due to moral or religious objections.
- Guidance (ACA implementation FAQs Part 51 and Part 54) and a HHS, Labor and Treasury letter to group health plan sponsors and insurers cite complaints and public reports about potential violations of the contraceptive coverage mandate. The FAQs make clear that even if not specifically identified in the current FDA Birth Control Guide, all FDA-approved, -cleared or -granted contraceptives that an individual's medical provider determines medically appropriate must be covered without cost sharing. This includes contraceptive products and services not included as types of contraception described in the HRSA-supported Women's Preventive Services Guidelines. Part 54 of the ACA implementation FAQs clarify how the contraceptive coverage requirements apply to fertility awareness-based methods and emergency contraceptives. Part 54 also confirms the federal requirement preempts any conflicting state law.
- If asserting a religious or moral objection, decide whether to voluntarily adopt an accommodation — or revoke an existing accommodation — allowing participants to obtain women's contraceptive coverage, if available, directly from the insurer or the TPA.

- Nongovernmental employers with sincerely held religious or moral objections to contraceptives may exclude ACA-mandated coverage of some or all FDA-approved women's contraceptives, under 2018 final regulations upheld by the Supreme Court (*Little Sisters of the Poor v. Pennsylvania*, 140 S. Ct. 2367 (2020)).
- The religious exemption is available to all types of nongovernmental employers, including nonprofit entities, privately held and publicly traded for-profit corporations, churches, and higher education institutions that arrange student health insurance coverage. The moral exemption is available to the same entities, with the exception of publicly traded corporations.
- Ongoing litigation on this issue and forthcoming proposed rules to amend the 2018 final rules leave uncertainty about the future of these exemptions.

Monitor ongoing litigation that could spare employer plan sponsors with religious objections from covering PrEP HIV medications and all nongrandfathered group health plans and insurers from covering ACA-mandated USPSTF-recommended preventive services without cost sharing.

- A federal district court in Texas held the requirement that group health plans and insurers cover PrEP HIV medication without cost sharing violated a private employer's rights under the Religious Freedom Restoration Act. The same court also held that USPSTF does not have constitutional authority to make coverage recommendations about other preventive services.
- The outcome of this case and the resulting group health plan implications are uncertain. Regardless of how the judge applies the ruling (e.g., only to the plaintiffs involved or as a nationwide injunction), the decision is certain to be appealed, perhaps all the way to the Supreme Court.
- If the decision stands, group health plans would no longer have to cover USPSTF-recommended preventive services without participant cost sharing.

Monitor ongoing litigation about instruction in fertility awareness-based methods.

- Another federal district court in Texas issued a preliminary nationwide injunction blocking HRSA's apparent elimination of the requirement to cover "instruction in fertility awareness-based methods" for women seeking alternatives to FDA-approved contraceptives. Since 2016, HRSA guidelines have required nongrandfathered group health plans and insurers to cover the full cost of this instruction, just like FDA-approved contraceptives. However, in December 2021, HRSA deleted the sentence requiring this coverage. The preliminary nationwide injunction issued in August 2021 restores that sentence, with the court finding elimination of the coverage requirement without any notice and comment period likely violated the Administrative Procedure Act. As a result, HRSA's guidelines include this sentence: "Additionally, instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method."
- Group health plans and issuers should review whether they cover without cost sharing instruction in fertility awareness-based methods for women who want an alternative to FDA-approved contraceptives. Plans and issuers also should monitor this litigation as it proceeds through the courts.

Update official plan documents, SPDs, SBCs and other materials as needed.

Related resources

Section 9

Other ongoing ACA concerns

Action

Review 2023 group health plan coverage and eligibility terms in light of ESR strategy, ESR and MEC reporting duties, and ACA benefit mandates. Consider the plan impact (if any) now that the "family glitch" for affordable coverage is fixed. Ensure that any rehired retirees are not covered under a "retiree only" plan exempt from many ERISA and ACA requirements. Comply with new obligations under the ACA Section 1557 rules (see Gender and family planning issues in benefits). Continue to calculate and pay the PCORI fee for self-funded health plans, and prepare for MLR rebates. Monitor ongoing litigation challenging various ACA provisions, including the obligation for nongrandfathered group health plans to cover ACA-mandated USPSTF-recommended preventive services without participant cost sharing.

Specific steps

Review planned 2023 benefits against ESR standards, including MEC for ACA full-time employees and the affordability and minimum value of health coverage.

- **Affordability.** Evaluate required employee contributions for the lowest-cost, self-only option against the 2023 affordability percentage and the employer affordability safe harbors. For 2023, the ESR required contribution percentage will decrease to 9.12%, down from 9.61% in 2022.
  - **2023 calendar-year plans.** The maximum monthly 2023 employee contribution for the lowest-cost, self-only option for employers using the federal poverty level (FPL) affordability safe harbor will slightly increase to $103.28, from $103.15 in 2022.
    - This marks the first time that the ESR required contribution percentage has decreased below 9.5%, but the maximum monthly contribution has hardly changed, due to increases to the FPL.
  - **Noncalendar-year plans beginning in 2023.** Noncalendar-year plans may use the FPL in effect within six months before the first day of the plan year. This means noncalendar-year plans starting in February to July 2023 (if the 2023 FPL is issued in January) or starting in March to August 2023 (if the 2023 FPL is issued in February) may use either the 2022 FPL of $13,590 — resulting in a FPL affordability safe harbor of $103.28 per month — or the 2023 FPL. These noncalendar-year plans would likely benefit from waiting to use the 2023 FPL since it will probably exceed the 2022 FPL and yield a higher FPL safe harbor contribution limit [(9.12% x 2023 FPL) ÷ 12]. However, depending on when the 2023 plan year starts and the 2023 FPL is issued, waiting for the 2023 FPL may not be practicable. Note: Noncalendar-year plans beginning in 2022 continue to use $103.15 as the FPL safe harbor amount for months in 2023 until their new 2023 noncalendar-year plan starts.
- **Minimum value.** Recently issued final regulations clarify that the minimum value requirements for coverage provided to employee family members are the same as for

employees. In addition, a plan will fail to meet the minimum value requirements unless it provides substantial coverage of inpatient hospital and physician services.

- **Assessments.** According to updated IRS Q&As (#55), the 2023 ESR assessments will be:
  - $2,880 (up from $2,750 in 2022) per ACA full-time employee for employers that do not offer MEC to at least 95% of ACA full-time employees (and their dependents), if at least one of those employees receives federally subsidized coverage through a public exchange
  - $4,320 (up from $4,120 in 2022) per ACA full-time employee receiving federally subsidized coverage through a public exchange because the employee wasn't among the 95% of ACA full-time employees offered employer MEC or received an offer of employer MEC that was unaffordable or less than minimum value

Consider the plan impact, if any, now that the family glitch is fixed.

- Recently issued final rules allow employee family members to receive premium tax credits (PTCs) for public exchange coverage beginning in 2023. Family members of employees who are offered affordable self-only coverage but unaffordable family coverage may now qualify for public exchange PTCs. As a result, more individuals should qualify for PTCs, and coverage should expand to more uninsured individuals. However, this rule could face court challenges.
  - **Affordability of employer coverage for employees' family members** will now be determined by reference to employee's required contribution for the lowest-cost, other than self-only coverage (e.g., family coverage) that provides minimum value. Under the prior rule, the lowest-cost employee-only coverage as a percentage of household income determined the affordability of employer-provided coverage for employees' family members.
  - **Affordability determination for an employee is unchanged** and remains based on the employee's required contribution for the lowest-cost, self-only coverage that provide minimum value as a percentage of household income. However, for offers of MEC to ACA full-time employees, employers may still use one of three employer affordability safe harbors — the W-2 wages, rate-of-pay or FPL safe harbor — for ESR compliance purposes.
  - **These rules DO NOT affect employer assessments or ESR compliance strategy.**
    - ESR compliance is still based solely on the lowest-cost, self-only coverage providing minimum value.
    - ACA information reporting (Forms 1094/1095) will not change, according to IRS.

Decide whether to amend a cafeteria plan's midyear election change rules to let family members drop employer coverage to obtain public exchange coverage.

- Under recent guidance, employers can, but don't have to, amend their cafeteria plans beginning with the 2023 plan year to allow a new permitted midyear change in elections:
  - A participant can revoke an election for other than self-only coverage (e.g., family coverage) under a group health plan so one or more family members can enroll in public exchange coverage.
  - The new election change means family members can opt out of employer-sponsored MEC to enroll in exchange coverage and receive PTCs.
  - Plan amendments must be made by the end of the first plan year in which the plan permits this new type of midyear election change. (For the 2023 plan year, amendments can be made at any time on or before the last day of the plan year that begins in 2024.)
  - Requirements for the new type of midyear election change include the following:
    - One or more family members must be eligible for a special enrollment period (e.g., due to a change in residence) or the open enrollment period for public exchange coverage.
    - The revocation of coverage under the group health plan must correspond to intended enrollment for public exchange coverage that is effective by the day after the last day of group health plan coverage.
    - The employee either must revoke his or her own coverage or elect self-only coverage (or family coverage for individuals other than the family member(s) seeking public exchange coverage).
    - The cafeteria plan may rely on the employee's reasonable representation that the employee and/or related individuals have timely enrolled or intend to enroll in a qualified health plan through a public exchange.

Consider benefit-eligibility terms or health benefit alternatives for part-time or former employees who don't trigger ESR assessments when not offered MEC.

- Weigh how the need for employer coverage may change. Demand could increase due to COVID-19's long-term health effects or the pandemic's potential resurgence due to variants. Public exchange coverage may be more accessible now that IRA (Pub. L. No. 117-169) has extended the American Rescue Plan Act's temporary increase in subsidies for 2021 and 2022 through 2025.

Review any stand-alone telehealth program, expanded EAP or on-site clinic open to employees ineligible for the traditional group health plan.

- Agency guidance temporarily permits an excepted-benefit EAP to cover COVID-19 diagnostic and testing services and allows certain stand-alone telehealth programs to avoid many ERISA and ACA market reforms. (For more information, see COVID-19 pandemic winds down.) Employer on-site medical clinics can offer expanded services and retain excepted-benefit status in all circumstances (i.e., excepted-benefit status for on-site clinics is not dependent on temporary COVID-19 guidance).

Ensure the adequacy of ESR recordkeeping and reporting.

- Prepare to furnish individual statements and file required forms with IRS. Proposed IRS regulations provide an automatic 30-day extension (e.g., to March 2, 2023, for 2022 statements) of the deadlines for employers and insurers to furnish ACA individual statements on health coverage and/or offers of coverage to ACA full-time employees (Forms 1095-B and 1095-C). The proposed regulations would also allow an alternative method for furnishing individual statements related to MEC, as long as the penalty for failing to meet the individual mandate remains zero. Taxpayers may rely on these proposed rules until a final regulation is published in the *Federal Register*.

- Keep in mind the costs of ESR noncompliance since IRS continues to issue ESR assessments. The agency first began notifying employers in late 2017 about their potential liability for the 2015 calendar year (when the ESR mandate took effect). IRS has actively collected assessments from applicable large employers every year since. In a December 2019 memorandum, the agency concluded that no statute of limitations applies to ESR assessments, suggesting assessment letters could come more than three years after the calendar year to which they apply.

- Check for reporting errors that can result in inaccurate ESR assessments. The Treasury Inspector General for Tax Administration (TIGTA) finds that employer reporting errors cause most adjustments to proposed ESR assessments. Some employers have made the same reporting error multiple years in a row. The most common mistake leading to a revised assessment involved reporting on Form 1094-C that the employer did not offer MEC to at least 95% of ACA full-time employees (and their dependents) when the employer actually did satisfy that threshold.

- Address any Form 1094-C or 1095-C reporting deficiencies identified in an initial IRS assessment Letter 226-J, and correct prior-year reports as necessary. Confirm that recordkeeping suffices to respond to any future IRS assessment letters.

- Plan for 2022 reports due in 2023, and continue to collect information for 2023 reports due in 2024. Confirm the appropriate measurement method — lookback or monthly — is used to identify ACA full-time employees.

- If offering an ICHRA, review the 2022 IRS Form 1095-C and instructions for line 14 codes designed to accommodate ESR and PTC reporting.

Review plan design for compliance with ACA benefit mandates.

- **ACA benefit mandates.** Continue to comply with ACA benefit mandates, such as the waiting-period restrictions, ban on lifetime and annual dollar limits for EHBs, required first-dollar coverage of specified preventive services (see Preventive services), and 2023 annual in-network out-of-pocket maximums (OOPMs) for EHBs (i.e., $9,100 for self-only and $18,200 for other than self-only coverage).

- **Retiree only plans.** With the possibility of retirees returning to the workforce as the pandemic winds down, ensure that active employees (including rehired retirees) are not included in the retiree-only plan. (Many ERISA and ACA requirements do not apply to a retiree-only plan if it has no more than one participant who is an active employee on the first day of the plan year.)

- **Grandfathered plans.** Employers sponsoring grandfathered plans should review the final triagency regulations, first applicable on June 15, 2021, that amend the requirements for preserving grandfathered status. The final rules provide an alternative inflation measure, based on the HHS annually published premium adjustment percentage, to determine the maximum increase in the fixed-dollar cost-sharing amounts that will not cause a plan to lose grandfathered status. According to regulators, this alternative inflation measure better accounts for changes in health coverage costs over time, potentially allowing grandfathered plans to maintain that status longer. The final rule also allows HSA-qualifying HDHPs to make IRS-required increases to minimum annual deductibles, even if the added amount exceeds the maximum percentage increase permitted by the grandfathered health plan rule. To date, however, the annual cost-of-living adjustment to HDHP minimum annual deductibles has yet to exceed the maximum percentage increase that would cause loss of grandfathered status.

Confirm use of most recent SBC templates during open enrollment.

- Use the most recent models to prepare SBCs for open enrollment. The most recent model was issued for the first plan year starting on or after Jan. 1, 2021. Materials include an SBC template, a uniform glossary, a sample completed SBC, instructions and guides for coverage example calculations — each in multiple languages. Changes to the coverage calculator may result in different values for coverage examples, even when the plan design has not changed. Review updated instructional guides for specific instructions on how to account for HRAs, HSAs and other healthcare accounts, along with health plan features like wellness programs.

Review any proposed changes to selected state benchmark plans.

- If using a state benchmark plan to identify which covered benefits are — or are not — EHBs subject to in-network OOPMs and the ban on annual or lifetime dollar limits, review the selected benchmark for any changes applicable in 2023, and consider other states' updates (if any).

Continue to calculate and pay the PCORI fee for self-funded group health plans, including certain HRAs and retiree-only plans.

- The PCORI fee remains in place for plan years ending before Oct. 1, 2029 (i.e., through the 2028 calendar-year plan). The fee funds research on the clinical effectiveness of various medical treatments and care options. Insurers are responsible for paying the fee for insured plans.
  - The fee due July 31, 2023, for noncalendar-year or short calendar-year plans ending in 2022 before Oct. 1 is $2.79 (up from $2.66 for the prior year) multiplied by the average number of lives covered under the plan.
  - The adjusted applicable fee per covered life due July 31, 2023, for 2022 calendar-year plans and noncalendar-year plans ending in 2022 on or after Oct. 1 is typically announced in the late fall/early winter

If sponsoring a fully insured group health plan, prepare for continued MLR rebates. ACA requires these rebates if an insurer fails to spend a minimum percentage of premiums on healthcare claims and quality improvements.

- Review plan documents for language addressing the handling of rebates, and follow those provisions accordingly. If plan documents are silent, consider an amendment to address rebates, refunds, plan distributions and other details. When the plan document is silent, the employer must determine how much of the rebate is a plan asset that must be used to benefit participants.
  - Nonfederal government employers and church plans should consult HHS rules on the management of MLR rebates.
  - Once informed about an insurer's intent to issue a rebate, communicate with plan participants on how the rebate will be handled.

Monitor ongoing litigation challenging certain ACA provisions and/or implementing regulations.

- Legal challenges to specific ACA regulations are ongoing, including litigation over the Section 1557 nondiscrimination rules (see Gender and family planning issues in benefits), moral and religious exemptions from the women's contraceptive coverage mandate, and mandated coverage of other preventive services (see Preventive services). These matters will likely take years to resolve, but agencies could change some regulations before the court challenges are complete.

Related resources

Section 10

HSA, HRA and FSA developments

Action

For 2023, discontinue changes made by temporary COVID-19 relief, unless extended or made permanent by future legislation or agency guidance. Decide whether to continue (or to adopt) the permanent enhancements to account-based plans under the CARES Act, the IRA and IRS guidance. Amend Section 125 cafeteria plans for changes implementing COVID-19 relief; final amendments for calendar-year plans generally are due by Dec. 31, 2022, but noncalendar-year plans may have until the last day of the 2022–2023 plan year for certain amendments. Update HDHPs and account-based plans for indexed dollar limits. Identify pre- or no-deductible health benefits, programs or point solutions that could jeopardize an individual's eligibility for HSA contributions, and confirm strategy. Consider whether pending IRS regulations on ICHRAs or DPCAs will impact benefit strategies and compliance efforts. Review future IRS guidance on the definition of a tax dependent for any impact on account-based plans.

Specific steps

Discontinue changes made by temporary COVID-19 relief. Monitor whether future legislation (e.g., S 1704 and HR 5981) or regulatory relief extends the temporary relief or makes it permanent.

- **Stop first-dollar or predeductible telehealth coverage under HSA-qualifying HDHPs by Jan. 1, 2023, unless the current relief is extended or made permanent.** Temporary relief under the 2022 CAA permits HSA-qualifying HDHPs to cover telehealth and other remote care on a first-dollar or predeductible basis. The relief also allows an otherwise HSA-eligible individual to receive first-dollar or predeductible coverage for telehealth and other remote care from a stand-alone vendor outside of the HDHP. In both cases, the first-dollar or predeductible telehealth coverage won't jeopardize an individual's HSA eligibility. This relief expires on Dec. 31, 2022, unless Congress enacts a temporary or permanent extension (for more information on the potential extension, see COVID-19 pandemic winds down). Absent an extension, HDHP/HSA participants should pay for the fair market value of any predeductible telehealth services that are not HSA-compatible preventive care, beginning Jan. 1, 2023. Review whether plan communications about telehealth coverage clearly indicate that the relief is temporary; if not, prepare additional communications, as discussed in FAQs Part 43, Q&A-13.
- **Administer health FSA and HRA deadlines in accordance with the outbreak period relief.** The Treasury Department and DOL have extended the filing deadline for HRA or health FSA claims by up to one year during the COVID-19 "outbreak period." The outbreak period began March 1, 2020, and will end 60 days after the announced end of the COVID-19 NE (last extended by the president on Feb. 18, 2022). The COVID-19 NE is currently set to expire March 1, 2023, unless terminated earlier or further extended.
  - Confirm that HRA and health FSA claim vendors still extend the run-out deadline, and participants have been notified about the duration of this extension.

- Watch for any official congressional or presidential action to terminate or extend the COVID-19 NE.
- Remember that this deadline relief (grounded in ERISA) does not apply to dependent care FSAs.

  Example. Peter contributed to a 2022 calendar-year health FSA with a 90-day claim run-out period, allowing submission of 2022 claims through March 31, 2023. Under the temporary relief, the run-out period for 2022 health FSA claims closes 90 days from the *earlier of* these dates:

  i. One year after the date Peter first became eligible for relief (for example, if Peter first became eligible for the relief on Jan. 1, 2023, the run-out period would end March 30, 2024)

  ii. The end of the outbreak period (for example, if the COVID-19 NE expires on March 1, 2023, the outbreak period would end 60 days later on April 30, 2023, giving Peter until July 29, 2023, to submit claims)

- **Stop any temporary FSA relief permitted by the 2021 CAA or IRS Notice 2021-15.** Many employers may have already discontinued this relief. But the following optional relief does not extend beyond 2022:
  - **Uncapped carryovers.** For plan years ending in 2021, unlimited health and dependent care FSA balances could carry over into the 2022 plan year. For plan years ending in 2022 (Dec. 31, 2022, for calendar-year plans) or later, unlimited carryovers into the next plan year are prohibited, and any balance remaining on the last day of the plan year generally must be forfeited. However, *health FSAs* may permit a carryover of up to $570 (annually indexed) into the 2023 plan year from the balance available at the end of the 2022 plan year. Alternatively, *both types of FSAs* may allow a 2-1/2–month grace period after the plan year ending in 2022 (e.g., through March 15, 2023, for a calendar-year plan). During that 2-1/2–month grace period, any balance will be available for newly incurred claims.
  - **Extended grace periods.** For plan years ending in 2021, health and dependent care FSAs could extend grace periods up to 12 months after plan year-end. Any balance that remained at the end of the grace period in 2022 generally was forfeited. However, if the FSA extended the grace period for the full 12 months, the standard rules allow an employer to offer a grace period for the first 2-1/2 months after the plan year ending in 2022 (e.g., through March 15, 2023, for a calendar-year plan). During that 2-1/2–month grace period, any balance will be available for newly incurred claims. Alternatively, a *health FSA* may be amended to permit a carryover of up to $570 (annually indexed) into the 2023 plan year from the balance available at the end of the 2022 plan year. The balance carried over into the 2023 plan year may include amounts contributed in 2021 if the health FSA allowed the full 12-month grace period.

Decide whether to continue (or to adopt) the permanent enhancements to account-based plans under the CARES Act, the IRA and/or IRS guidance.

- **Maximum health FSA carryover.** IRS Notice 2020-33 permits — but does not require — a health FSA to increase the carryover limit into the next plan year to 20% of the current year's salary-reduction contribution limit. So for health FSA plan years starting in 2022, the maximum carryover to the next plan year is $570 (20% of the 2022 salary-reduction

contribution limit of $2,850). For health FSA plan years starting in 2023, the maximum carryover amount to the 2024 plan year will be $610 (20% of the 2023 salary-reduction contribution limit of $3,050).

- **HSA, HRA and health FSA reimbursement of costs for OTC drugs without a prescription, menstrual care products and COVID-19 personal protective equipment (PPE).** The CARES Act and IRS Announcement 2021-7 permit — but do not require — HRAs and health FSAs to reimburse costs for OTC drugs without a prescription, menstrual care products and COVID-19 PPE, such as hand sanitizer, face masks and sanitizing wipes. For OTC drugs and menstrual care products, Section 125 plan sponsors must prospectively amend their cafeteria plans before those provisions take effect. For COVID-19 PPE, retroactive plan amendment by the end of 2022 is permitted. HSAs may reimburse such expenses on a tax-free basis.
- **HSA-qualifying HDHPs may permit first-dollar or predeductible coverage of COVID-19 testing and treatment.** "Until further guidance is issued," IRS Notice 2020-15 permits HSA-qualifying HDHPs to cover COVID-19 testing and treatment before individuals have met the deductible, without jeopardizing their eligibility to make or receive HSA contributions. HDHPs must cover COVID-19 *testing* without cost sharing during the COVID-19 PHE (currently renewed through Jan. 10, 2023). However, HDHP coverage for COVID-19 *treatment* without cost sharing is optional.
- **HSA-qualifying HDHPs may permit first-dollar or predeductible coverage of insulin.** The IRA codifies (and potentially expands) Notice 2019-45 to allow HSA-qualifying HDHPs to cover "selected insulin products" on a first-dollar or predeductible basis. For this purpose, selected insulin products means any dosage form (e.g., vial, pump or inhaler) of any type (e.g., rapid-acting, short-acting, intermediate-acting, long-acting, ultra long-acting or premixed) of insulin. The purpose does not need to be related to treatment for diabetes.

Amend Section 125 plans for changes implementing COVID-19 relief before Jan. 1, 2023, for calendar-year plans or by the applicable deadline for noncalendar-year plans.

- **Amend the Section 125 plan for any relief offered employees.** Although Section 125 plan documents usually must be amended before a change takes effect, COVID-19 relief permits retroactive amendments within specific time frames. Different deadlines for noncalendar-year plans are noted below, but work with counsel to confirm the deadlines for a particular noncalendar-year plan.
- **Plan amendments due by Dec. 31, 2022 (or by the applicable noncalendar-year plan deadline):**
  - Amendment allowing employees to revoke an FSA election, make a new FSA election, or decrease or increase an existing FSA election without a change-in-status event during the plan year ending in 2021
  - Amendment allowing uncapped FSA carryover amounts from the plan year ending in 2021 into the plan year ending in 2022
  - Amendment extending the FSA grace period from 2-1/2 months to as many as 12 months after the plan year ending in 2021

  - Amendment permitting health FSAs (HRAs may need a similar amendment) to reimburse participants' costs for COVID-19 PPE, if this change first took effect during 2021
  - Amendment for a calendar-year plan increasing the health FSA carryover amount to $570 (indexed annually) from the 2022 plan year into the 2023 plan year, if this change first takes effect for the 2022 plan year
    - For noncalendar-year plans beginning in 2022, the deadline is the last day of the 2022–2023 plan year.

Update HSA, HDHP and excepted-benefit HRA limits for 2023 amounts announced in Rev. Proc. 2022-24, and revise 2023 health FSA limits announced in Rev. Proc. 2022-38.

- **HSA annual contribution limits.** The 2023 contribution limits will increase to $3,850 (self-only) and $7,750 (family) — up from $3,650 and $7,300 in 2022. The annual catch-up contribution for individuals ages 55 and older remains $1,000 (not indexed).
- **HDHP in-network OOPMs.** The 2023 OOPM will increase to $7,500 (self-only) and $15,000 (family) — up from $7,050 and $14,100 in 2022. HDHPs may set lower — but not higher — caps on in-network OOP expenses. The ACA's higher OOPMs ($9,100 for self and $18,200 for family coverage in 2023) for nongrandfathered group health plans apply only when an HDHP must embed an ACA individual in-network OOP limit into family HDHP coverage.
- **HDHP minimum annual deductible.** The 2023 minimum deductibles will increase to $1,500 (self-only) and $3,000 (family) — up from $1,400 and $2,800 in 2020, 2021 and 2022.
- **Excepted-benefit HRA annual maximum contribution.** The 2023 maximum annual employer contribution to an excepted-benefit HRA will increase to $1,950, up from $1,800 in 2020, 2021 and 2022.
- **Health FSA annual salary-reduction contribution limit, carryover limit.** As stated above, the 2023 salary reduction contribution limit will increase to $3,050, up from $2,850 in 2022, and the maximum health FSA carryover amount from health FSA plan years starting in 2023 to the 2024 plan year will increase to $610, up from $570.

Identify first-dollar or predeductible health benefits, programs or point solutions that could jeopardize an individual's eligibility for HSA contributions, and confirm strategy.

- Look broadly at telehealth services (unless COVID-19 temporary relief is extended beyond 2022), on-site medical clinics, wellness programs, expert medical-opinion services, executive supplemental health benefits, international and travel health plans, coupons for prescription drugs or manufacturer cost-sharing assistance, or specialized care or disease-management programs. Examples of such programs include diabetes control, genetic tests, sleep apnea treatment, maternity support, fertility and infertility services, and behavioral health support. Long-standing IRS guidance permits HSA-qualifying HDHPs to provide first-dollar or predeductible preventive care and health benefits that don't provide significant medical care or treatment benefits, such as certain on-site clinics, disease-management programs, wellness programs or EAPs.

Consider whether pending proposed IRS regulations on ICHRAs or DPCAs and future anticipated regulations on tax dependents will influence benefit strategy and compliance efforts.

- **ICHRAs.** IRS anticipates issuing by the end of 2022 final regulations detailing how ICHRAs interact with the ACA's ESR requirements and the nondiscrimination rules for self-funded group plans under Section 105(h) of the tax code. For now, employers may rely on the 2019 proposed regulations. Employers offering or considering ICHRAs should monitor whether IRS issues new final rules on how an employer offering ICHRAs can avoid ESR assessments.
- **DPCAs.** A DPCA is a contract between an individual and one or more primary care physicians who agree to provide medical care for a fixed annual or periodic fee without billing a third party. Proposed 2020 IRS regulations would allow HRAs to reimburse all types of DPCA fees, but health FSA and HSA reimbursements are likely limited to DPCA charges for medical care (but not membership fees, which might be viewed as akin to insurance premiums). The latest semiannual regulatory agenda indicates IRS may finalize these rules by June 2023. Employers whose benefit strategy includes DPCAs should monitor whether IRS pursues a different course under the Biden administration. Finally, as long as a DPCA is considered a health plan or medical insurance, an individual covered by the DPCA cannot make or receive HSA contributions. (Note that legislation may be introduced in 2023 to allow HSA-eligible individuals covered by DPCAs to make or receive HSA contributions.)
- **Tax dependents.** The latest semiannual regulatory agenda calls for finalizing by June 2023 IRS rules (proposed in 2017) clarifying the definition of tax dependent under Section 152. Review these rules once issued for any impact on HRA, HSA or health FSA reimbursements.

Related resources

Appendix A
Related resources

1. Prescription drugs

Non-Mercer resources

- Prescription drug data collection (RxDC) website (CMS)
- Executive Order 14087, Lowering prescription drug costs for Americas (Federal Register, Oct. 19, 2022)
- RxDC FAQs (CMS, Oct. 4, 2022)
- RxDC file templates (CMS, June 29, 2022)
- RxDC reporting instructions (CMS, June 29, 2022)
- *American Hospital Association v. Becerra*, 142 S. Ct. 1896 (2022)
- Press release, FTC launches inquiry into prescription drug middlemen industry (FTC, June 7, 2022)
- *Pharmaceutical Care Management Association v. Mulready*, No. 5:19-cv-00977-J (WD OK April 4, 2022)
- Interim final rule, Prescription drug and healthcare spending (Federal Register, Nov. 23, 2021)
- *Pharmaceutical Care Management Association v. Wehbi*, 18 F.4th 956 (2021)
- NSA § 204 in the 2021 CAA (Congress, Dec. 27, 2020)
- *Rutledge v. Pharmaceutical Care Management Association*, 140 S. Ct. 812 (2020)

Mercer Law & Policy resources

- Drug reporting rules present challenges for many (Aug. 26, 2022)
- Michigan enacts three new prescription drug laws (March 10, 2022)
- New York to regulate pharmacy benefit managers (March 3, 3022)
- Mercer, ERIC provide more input on CAA prescription drug reporting (Jan. 28, 2022)
- States seek to rein in Rx costs and pharmacy benefit managers (Oct. 26, 2021)

Other Mercer resources

- MercerRx
- Congress takes aim at PBM business practices (July 7, 2022)
- Drug pricing forecast: continued stormy weather (April 28, 2022)

2. Group health plan transparency

Non-Mercer resources

- Technical implementation guide for the triagency price transparency rule (GitHub, updated daily)
- Request for information, Advanced explanation of benefits and good-faith estimate for covered individuals (Federal Register, Sept. 16, 2022)
- ACA and 2021 CAA implementation FAQs Part 55 (DOL, Aug. 19, 2022)
- CMS technical clarification questions and answers (CMS, Sept. 23, 2022)
- 500 items and services list for price comparison tool (CMS, July 25, 2022)
- Enforcement actions (CMS, June 8, 2022)
- Hospital price transparency FAQs (CMS, May 6, 2022)
- ACA implementation FAQs Part 53 (DOL, HHS and Treasury, April 19, 2022)
- Field Assistance Bulletin No. 2021-03 (DOL, Dec. 30, 2021)
- Final rule updating hospital price transparency requirements (Federal Register, Nov. 16, 2021)
- Requirements related to air ambulance services, agent and broker disclosures, and provider enforcement (Federal Register, Sept. 16, 2021)
- ACA and CAA 2021 implementation FAQs Part 49 (DOL, HHS and Treasury, Aug. 20, 2021)
- Interim final rule, Requirements related to surprise billing; Part I (Federal Register, July 13, 2021)
- Executive Order 14036, Promoting competition in the American economy (White House, July 9, 2021)
- Pub. L. No. 116-260, the 2021 CAA (Congress, Dec. 27, 2020)
- Final transparency-in-coverage rule (Federal Register, Nov. 12, 2020)
- Final transparency rule for hospitals (Federal Register, Nov. 27, 2019)

Mercer Law & Policy resources

- Mercer suggests array of healthcare policy improvements to Congress (March 11, 2022)
- 2022 health law and policy outlook (Feb. 24, 2022)
- Health plans face new liabilities for inaccurate provider directories (Jan. 4, 2022)

- Healthcare cost transparency rules and MLR changes finalized (Dec. 2, 2020)
- Mercer comments on proposed transparency-in-coverage rules (Jan. 31, 2020)
- Executive order targets healthcare price and quality transparency, and HSA/FSA changes (July 10, 2019)

Other Mercer resources

- CMS issues late-breaking guidance on posting machine-readable files (June 23, 2022)
- Regulators clarify implementation timeline of transparency provisions (Aug. 25, 2021)
- Biden executive order targets drug costs, other healthcare issues (July 15, 2021)
- Healthcare transparency rules (March 4, 2021)
- Transparency rules: 5 considerations for employers (Nov. 12, 2020)

3. Mental health parity

Non-Mercer resources

- Mental health parity and substance use disorder resources (DOL)
- *Wit v. United Behavioral Health*, Nos. 20-17363, 21-15193, 20-17364 and 21-15194 (9th Cir. March 22, 2022)
- 2022 MHPAEA report to Congress (DOL, HHS and Treasury, Jan. 25, 2022)
- Fact sheet: FY 2021 MHPAEA enforcement (DOL, Jan. 25, 2022)
- MH/SUD parity implementation and CAA 2021 FAQs Part 45 (DOL, HHS and IRS, April 2, 2021)
- Pub. L. No. 116-260, the 2021 CAA (Congress, Dec. 27, 2020)
- MHPAEA self-compliance tool (DOL, Oct. 20, 2020) (does not cover changes made by the 2021 CAA)

Mercer Law & Policy resources

- Mental health parity compliance gets a boost in 2021 spending act (April 13, 2021)
- Mental health parity FAQs address nonquantitative limits (Dec. 17, 2019)

Other Mercer resources

- [insert text]

4. COVID-19 pandemic winds down

Non-Mercer resources

- Coronavirus (COVID-19) website (CDC)

- COVID-19 workplace safety (OSHA)
- Coronavirus and COVID-19 (EEOC)
- Essential protections during the COVID-19 pandemic (DOL Wage and Hour Division)
- Pub. L. No. 117-103, Consolidated Appropriations Act, 2022 (March 15, 2022)
- Notice 2021-58, Extension of COBRA election and premium payment deadlines under Section 7508A(b) (IRS, Oct. 6, 2021)
- Guidance on 'long COVID' as a disability under the ADA, Section 504 and Section 1557 (HHS and Justice Department, July 26, 2021)
- Notice 2021-15, Additional relief for coronavirus disease (COVID-19) under § 125 cafeteria plans (IRS, March 2, 2021)
- Families First Coronavirus Response Act (FFCRA) and CARES Act implementation FAQs Part 44 (DOL, HHS and Treasury, Feb. 26, 2021)
- Disaster relief notice 2021-01 (DOL, Feb. 26, 2021)
- Interim final rule, Additional policy and regulatory revisions in response to the COVID-19 public health emergency (Federal Register, Nov. 6, 2020)
- FFCRA and CARES Act implementation FAQs Part 43 (DOL, HHS and Treasury, June 23, 2020)
- Notification of relief, Extension of certain time frames for employee benefit plans, participants and beneficiaries affected by the COVID-19 outbreak (Federal Register, May 4, 2020)
- Disaster relief notice 2020-01 (DOL, April 28, 2020)
- FFCRA and CARES Act implementation FAQs Part 42 (DOL, HHS and Treasury, April 11, 2020)
- Pub. L. No. 116-136, the CARES Act (Congress, March 27, 2020)
- Pub. L. No. 116-127, the FFCRA (Congress, March 18, 2020)
- FAQs on EHB coverage and COVID-19 (CMS, March 12, 2020)
- Notice 2020-15, HDHPs and expenses related to COVID-19 (IRS, March 11, 2020)

Mercer Law & Policy resources

- Roundup: Coronavirus (COVID-19) resources for employers (regularly updated)
- States, cities tackle COVID-19 paid leave (regularly updated)
- Deadline relief continues for health plans and participants (Nov. 12, 2021)
- IRS Q&As explain ARPA's COBRA premium subsidy program (Nov. 12, 2021)
- Agencies issue new FAQs on COVID-19 testing, vaccines (Oct. 6, 2021)

- DOL releases model COBRA subsidy notice and forms (April 20, 2021)
- Tracking federal COVID-19 laws affecting employee benefits, jobs (March 30, 2021)
- COBRA subsidies in COVID-19 rescue plan require employer action (March 29, 2021)
- COVID-19 vaccine considerations for group health plans (Dec. 21, 2020)
- Employer health plans have to meet new COVID-19 coverage mandate (April 21, 2020)
- COVID-19 raises HIPAA privacy, security issues (April 6, 2020)
- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)

Other Mercer resources

- Navigating coronavirus (regularly updated)
- Return to the workplace with confidence (regularly updated)
- Survey reveals COVID's continuing impact on US business (Oct. 20, 2022)
- Congress set to pass short-term renewal of predeductible telehealth coverage (March 10, 2022)
- House bill extends free COVID-19 testing mandate beyond emergency period (March 3, 2022)
- New FAQs clarify issues with OTC COVID-19 testing mandate (Feb. 10, 2022)
- Covering at-home COVID-19 tests: Your top questions answered (Jan. 20, 2022)
- Plans must cover at-home OTC COVID-19 tests for free (Jan. 12, 2022)
- COVID-19 relief for health plans: How long does it last? (Nov. 4, 2021)
- EEOC: Vaccine incentives are permitted (June 3, 2021)
- IRS clarifies FSA relief in CAA, provides more flexibility for cafeteria plan elections (Feb. 25, 2021)
- Employers can mandate the COVID-19 vaccine, but should they? (Dec. 10, 2020)
- Employer groups encourage federal funding, support for COVID-19 testing (July 23, 2020)
- Tough issue arising as workers return: At-risk employees and the ADA (July 16, 2020)

5. Gender and family planning issues in benefits

Non-Mercer resources

- Section 1557 of the Patient Protection and Affordable Care Act (HHS webpage)
- Sexual orientation and gender identity discrimination (EEOC)
- 42 USC § 18116, ACA Section 1557 (US Code)
- 26 USC § 137, Internal Revenue Code Section 137 (US Code)
- Publication 502, Medical and dental expenses (IRS, updated annually)
- *Williams v. Kincaid,* No. 21-2030 (4th Cir. Aug. 16, 2022).
- Proposed rule, Nondiscrimination in health programs and activities (Federal Register, Aug. 4, 2022)
- Executive Order 14079, Securing access to reproductive and other healthcare services (White House, Aug. 3, 2022)
- ACA implementation FAQs Part 54, Preventive services requirements for contraceptive coverage (July 28, 2022)
- Executive Order 14076, Protecting access to reproductive healthcare services (White House, July 8, 2022)
- HIPAA privacy rule and disclosures of information relating to reproductive healthcare (June 29, 2022)
- Triagency letter to plans and issuers on access to contraceptive coverage (DOL, HHS and Treasury, June 27, 2022)
- *Dobbs v. Jackson Women's Health Organization,* 141 S. Ct 2228 (2022)
- Notice and guidance on gender affirming care, civil rights and patient privacy (HHS, March 2, 2022)
- Notification of interpretation and enforcement of ACA Section 1557 and Title IX of the Education Amendments of 1972 (Federal Register, May 25, 2021)
- Executive Order 13988, Preventing and combating discrimination on the basis of gender identity or sexual orientation (Federal Register, Jan. 25, 2021)
- PLR 202114001 IRS, Jan. 12, 2021)

Mercer Law & Policy resources

- Domestic partner benefits remain popular but present challenges (June 13, 2022)

- A primer on ERISA's preemption of state laws (March 22, 2022)
- ACA 1557 nondiscrimination rule revised, but what is effective now? (Nov. 5, 2020)
- Justices' Title VII ruling on LGBTQ bias has health benefit impacts (June 15, 2020)

Other Mercer resources

- Survey finds employers expanding medical travel benefits (Oct. 27, 2022)
- Poll finds employers considering travel and lodging benefits for abortion services (July 7, 2022)
- Medications for pregnancy termination in a post-*Dobbs* world (June 30, 2022)
- SCOTUS overturns *Roe*: Understanding the impact on your benefit plans (June 24, 2022)
- Lifestyle spending accounts: Your top questions answered (May 19, 2022)
- Turning health risk into value: Are your health and well-being approaches inclusive? (June 9, 2021)
- New survey finds employers adding fertility benefits to promote DEI (May 6, 2021)
- On the DEI journey, health equity must be a goal (March 11, 2021)
- Supreme Court's LGBTQ decision spurs legislation, lawsuits (June 18, 2020)
- Historic ruling confirms LGBTQ+ work protections (June 15, 2020)
- Does your health plan meet the needs of transgender individuals? (March 27, 2019)
- Changes signal shift in diversity and inclusion benefits (Sept. 6, 2018)

6. Surprise billing

Non-Mercer resources

- No Surprises Act webpage (EBSA)
- Ending surprise medical bills webpage (CMS)
- Final rules, Requirements related to surprise billing (Federal Register, Aug. 26, 2022)
- Chart regarding applicability of the federal independent dispute resolution process in bifurcated states (CMS, Sept. 12, 2022)
- ACA and CAA 2021 implementation FAQs Part 55 (DOL, HHS and Treasury, Aug. 19, 2022)
- Federal independent dispute resolution process status update (DOL, HHS and Treasury, Aug. 19, 2022)
- Model disclosure notice regarding patient protections against surprise billing (CMS, June 14, 2022)

- Interim final rules, Requirements related to surprise billing; Part II (Federal Register, Oct. 7, 2021)
- Interim final rules, Requirements related to surprise billing; Part I (Federal Register, July 13, 2021)
- Pub. L. No. 116-260, the 2021 CAA (Congress, Dec. 27, 2020)

Mercer Law & Policy resource

- Tracking federal COVID-19 laws affecting employee benefits, jobs (March 30, 2021)

Other Mercer resources

- Prepare to comply with No Surprises Act notice requirements (Dec. 16, 2021)
- Surprise billing interim final rule released (July 8, 2021)

7. State-mandated paid leave and other state law trends

Non-Mercer resources

- PSYPACT
- Supreme Court docket for *ERISA Industry Committee v. Seattle*, No. 21-1019 (filed Oct. 20, 2021)
- Supreme Court docket for *Ragan v. Ragan,* No. 21-1571 (filed June 15, 2022)

Mercer Law & Policy resources

- States, cities tackle COVID-19 paid leave (regularly updated)
- San Francisco updates contractor-lessee health plan standards, pay rates (Aug. 31, 2022)
- Roundup of selected state health developments, second-quarter 2022 (Aug. 22, 2022)
- Massachusetts sets 2023 individual-mandate coverage dollar limits (Aug. 12, 2022)
- Maryland passes paid family and medical leave law (Aug. 11, 2022)
- San Francisco Health Care Expenditure rates released for 2023 (Aug. 8, 2023)
- Delaware enacts paid family and medical leave law (July 7, 2022)
- Seattle posts 2023 health expenditure rate for hotel employers (July 5, 2022)
- Colorado moves forward on paid family and medical leave (June 30, 2022)
- Roundup of selected state health developments, first-quarter 2022 (May 31, 2022)
- Roundup: State accrued paid leave mandates (April 29, 2022)
- Washington enacts numerous benefit, insurance and related laws (April 14, 2022)
- Washington changes long-term care law (April 13, 2022)

- San Francisco's annual Health Care Expenditure report due May 2 (March 31, 2022)
- A primer on ERISA's preemption of state laws (March 22, 2022)
- Hawaii employee health and leave benefits may need special attention (Feb. 18, 2022)
- Illinois mandates health plan disclosure with EHB comparison (Feb. 10, 2022)
- New York announces 2022 HCRA covered-lives assessment rates (Jan. 31, 2022)
- States update group health plan sponsor reporting obligations (Jan. 21, 2022)
- Roundup of selected state health developments, fourth-quarter 2021 (Jan. 21, 2022)
- 2022 state paid family and medical leave contributions and benefits (Jan. 19, 2022)
- Connecticut readies its paid family and medical leave program (Dec. 2, 2021)
- California expands health insurance mandates, modifies leave laws (Nov. 2, 2021)

Other Mercer resources

- Life, absence & disability management

8. Preventive services

Non-Mercer resources

- Preventive health services (Healthcare.gov)
- A and B recommendations (USPSTF)
- Vaccine recommendations and guidelines (ACIP)
- Women's preventive services guidelines (HRSA)
- *Braidwood Mgmt. Inc. v. Becerra*, No. 4:20-cv-00283-O (ND TX Sept. 27, 2022)
- Creating a roadmap for the end of the COVID-19 public health emergency (CMS, Aug. 18, 2022)
- *Tice-Harouff v. Johnson,* No. 6:22-cv-201-JDK (ED TX Aug. 12, 2022)
- ACA implementation FAQs Part 54 (DOL, HHS and Treasury, July 28, 2022)
- ACA, FFCRA and CARES Act implementation FAQs Part 51 (DOL, HHS and Treasury, Jan. 10, 2022)
- ACA, HIPAA and CARES Act implementation FAQs Part 50 (DOL, HHS and Treasury, Oct. 4, 2021)
- Letter to the governors on the COVID-19 response (HHS, Jan. 21, 2021)
- Pub. L. No. 116-260, the 2021 CAA (Congress, Dec. 27, 2020)
- *Little Sisters of the Poor v. Pennsylvania*, 140 S. Ct. 2367 (2020)

- Final rule, Moral exemptions and accommodations for coverage of certain preventive services under the ACA (Federal Register, Nov. 15, 2018)
- Final rule, Religious exemptions and accommodations for coverage of certain preventive services under the ACA (Federal Register, Nov. 15, 2018)
- Final rule, Coverage of certain preventive services under the ACA (Federal Register, July 14, 2015)

Mercer Law & Policy resources

- IRS expands predeductible preventive care for HSA-qualifying health plans (July 23, 2019)

Other Mercer resources

- Will a court decision change preventive care coverage? (Sept. 15, 2022)
- Should employers cover colon cancer screenings at age 45? (June 24, 2021)
- Why do I keep getting billed for preventive health services? (Oct. 25, 2018)
- Contraceptive coverage: Good for women, good for business (July 12, 2018)

9. Other ongoing ACA concerns

Non-Mercer resources

- Information on EHB benchmark plans (CMS)
- Medical loss ratio (CMS)
- Final rule, Affordability of employer coverage for family members of employees (Federal Register, Oct. 13, 2022)
- Notice 2022-41 (IRS, Oct. 11, 2022)
- Information reporting by providers of minimum essential coverage (IRS, Sept. 29, 2022)
- Information reporting by applicable large employers (IRS, Sept. 29, 2022)
- Employer shared-responsibility provisions (IRS, Sept. 29, 2022)
- *Braidwood Mgmt. Inc. v. Becerra*, No. 4:20-cv-00283-O (ND TX Sept. 7, 2022)
- Rev. Proc. 2022-34 (IRS, July 29, 2022)
- PCORI fee (IRS, March 4, 2022)
- Poverty guidelines for 2022 (HHS, Jan. 21, 2022)
- Notice 2022-04 (IRS, Dec. 21, 2021)

- Premium adjustment percentage, maximum annual limitation on cost sharing, reduced maximum annual limitation on cost sharing and required contribution percentage for the 2023 benefit year (CMS, Dec. 28, 2021)
- Information reporting of health insurance coverage and other issues (Federal Register, Dec. 6, 2021)
- FFCRA and CARES Act implementation FAQs Part 44 (DOL, HHS and Treasury, Feb. 26, 2021)
- Final rule, Grandfathered group health plans and grandfathered group health insurance coverage (Federal Register, Dec. 15, 2020)
- FFCRA and CARES Act implementation FAQs Part 43 (DOL, HHS and Treasury, June 23, 2020)
- Improvements are needed to ensure employer shared-responsibility payments are properly assessed (TIGTA, June 10, 2020)
- Memorandum 20200801F, Statute of limitations for IRC § 4980H (IRS, Dec. 26, 2019)
- ACA implementation FAQs Part III (DOL, HHS and Treasury, Oct. 12, 2010)

Mercer Law & Policy resources

- 2023 quick benefit facts (Oct. 21, 2022)
- Affordability percentage for employer health coverage will shrink in 2023 (Sept. 14, 2022)
- HHS adjusts 2022 HIPAA, certain ACA and MSP monetary penalties (March 23, 2022)
- Summary of 2022 benefit-related cost-of-living adjustments (Jan. 19, 2022)
- Proposed regulations extend ACA individual statement due dates (Dec. 1, 2021)
- Employers face ongoing liability for ACA play-or-pay assessments (March 2, 2020)

Other Mercer resources

- Major Medicare drug price reforms to become law but leave out employer plans (Aug. 11, 2022)
- Time to revisit your ACA affordability strategy? (Sept. 30, 2021)

10. HSA, HRA and FSA developments

Non-Mercer resources

- Publication 15-B, *Employer's tax guide to fringe benefits* (IRS, annually updated)
- Publication 502, *Medical and dental expenses* (IRS, annually updated)
- Publication 969, *HSAs and other tax-favored health plans* (IRS, annually updated)

- Rev. Proc. 2022-38 (IRS, Oct. 18, 2022)
- Renewal of determination that a public health emergency exists (HHS, Oct. 13, 2022)
- Public L. No. 117-169, the Inflation Reduction Act of 2022 (Congress, Aug. 16, 2022)
- Health savings accounts (Congressional Research Service, Aug. 8, 2022)
- Agency rule list for spring 2022: Treasury Department (Office of Information and Regulatory Affairs, June 21, 2022)
- Rev. Proc. 2022-24, 2023 inflation-adjusted HSA,HDHP and excepted-benefit HRA amounts (IRS, April 29, 2022)
- Pub. L. No. 117-103, the 2022 CAA (Congress, March 15, 2022)
- Health reimbursement arrangements (HRAs): Overview and related history (Congressional Research Service, March 7, 2022)
- Continuation of the national emergency concerning the coronavirus disease 2019 (COVID–19) pandemic (White House, Feb. 18, 2022)
- HR 5981, Telehealth Expansion Act of 2021 (Congress, Nov. 15, 2021)
- S 1704, Telehealth Expansion Act of 2021 (Congress, May 19, 2021)
- A comparison of tax-advantaged accounts for healthcare expenses (Congressional Research Service, May 3, 2021)
- Announcement 2021-7, Amounts paid for certain personal protective equipment treated as medical expenses (IRS, March 26, 2021)
- EBSA Disaster Relief Notice 2021- 01 (DOL, Feb. 26, 2021)
- Notice 2021-15 (IRS, Feb. 18, 2021)
- Pub. L. No. 116-260, the 2021 CAA (Congress, Dec. 27, 2020)
- FFCRA and CARES Act implementation FAQs Part 43 (DOL, HHS and Treasury, June 23, 2020)
- Proposed rule, Certain medical care arrangements (Federal Register, June 10, 2020)
- Notice 2020-33, Modification of carryover rule for health FSAs and clarification of premium reimbursements by ICHRAs (IRS, May 12, 2020)
- Joint DOL and IRS notice, Extension of certain time frames for employee benefit plans, participants and beneficiaries affected by the COVID-19 outbreak (Federal Register, May 4, 2020)
- Pub. L. No. 116-136, the CARES Act (Congress, March 27, 2020)
- Notice 2020-15, HDHPs and expenses related to COVID-19 (IRS, March 11, 2020)
- Proposed rule, Application of the ESR provisions and certain nondiscrimination rules to HRAs and other account-based group health plans integrated with Individual health insurance coverage or Medicare (Federal Register, Sept. 30, 2019)

- Final rule, HRAs and other account-based group health plans (Federal Register, June 20, 2019)
- Individual-coverage and excepted-benefit HRAs FAQ s (DOL, HHS and Treasury, June 13, 2019)
- Proposed rule, Definition of dependent under the Working Families Tax Relief Act of 2004 (Federal Register, Jan. 19, 2017)

Mercer Law & Policy resources

- 2023 transportation and health FSA limits projected (July 19, 2022)
- 2023 HSA, HDHP and excepted-benefit HRA figures set (May 3, 2022)
- 2022 quick benefit facts (Jan. 19, 2022)
- Summary of 2022 benefit-related cost-of-living adjustments (Jan. 19, 2022)
- Deadline relief continues for health plans and participants (Nov. 12, 2021)
- Tracking federal COVID-19 laws affecting employee benefits, jobs (March 30, 2021)
- IRS offers relief to cafeteria plans, HDHPs, individual-coverage HRAs (May 28, 2020)
- CARES Act boosts telehealth, makes other health, paid leave changes (March 27, 2020)
- COVID-19 spurs IRS relief for HDHPs, state insurance guidance (March 18, 2020)
- IRS outlines how individual-coverage HRAs can meet ACA employer mandate (Oct. 29, 2019)
- IRS expands predeductible preventive care for HSA-qualifying health plans (July 23, 2019)
- Final rules ease restrictions on health reimbursement arrangements (June 14, 2019)

Other Mercer resources

- Hill healthcare agenda stalls as midterm elections loom (Sept. 15, 2022)
- Major Medicare drug price reforms to become law but leave out employer plans (Aug. 11, 2022)
- How to maximize HDHPs and HSAs to save costs, promote health and retain talent (March 17, 2022)
- Congress set to pass short-term renewal of predeductible telehealth coverage (March 10, 2022)
- Mercer, stakeholder groups urge Congress to extend predeductible telehealth coverage (Dec. 9, 2021)
- COVID-19 relief for health plans: How long does it last? (Nov. 4, 2021)
- Mercer CEO talks benefits policy in visit to Capitol Hill (April 14, 2021)

- New outbreak period guidance requires plan action (March 2, 2021)
- IRS clarifies FSA relief in CAA, provides more flexibility for cafeteria plan elections (Feb. 25, 2021)
- Direct primary care gains ground as employer strategy (July 9, 2020)
- Could free COVID-19 services sabotage your HSA? IRS just weighed in (March 12, 2020)

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