Employee Benefits and Executive Compensation: Getting Ready for 2024 - Health and Welfare Plan Developments
Hosts: Lynne Wakefield, Lydia Parker
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Lynne Wakefield:

Hi, everyone. You're tuned in to Troutman Pepper's *Employee Benefits and Executive Compensation Podcast* miniseries, your compass for navigating the complex world of benefits and compensation, as we close out 2023 and head into 2024. I'm Lynne Wakefield and I'm here with my co-host, Lydia Parker. We're both partners in the employee benefits and executive compensation practice at Troutman Pepper, and we both dedicate a substantial portion of our practice to advising clients on the wide variety of compliance issues that arise in the administration of health and welfare plans.

Lydia Parker:

Today we're going to be talking about some key health and welfare plan developments that plan sponsors should have on their radar as we close out 2023 and head into 2024. There's definitely been a lot going on in the health and welfare space over the last few years with legislative updates, regulatory developments, and increasing health and welfare related litigation.

Lynne Wakefield:

Yeah, Lydia, I agree. It seems like there's more than ever to keep up with and it's becoming increasingly difficult for plan sponsors to comply.

Lydia Parker:

Definitely. And I think self-insured plans are in a particularly bad spot, but let's talk about some things that every employer that sponsors a health plan should be thinking about. I know at this time of the year, the thing that's on top of my mind is year-end amendments. So what are you seeing on that front?

Lynne Wakefield:

Luckily, I think 2023 should be a comparatively light year. It seems like we're due for one of those. There's been a lot going on recent years. But with the COVID related outbreak period expiring earlier this year, plan sponsors who amended their plans to reflect the extension of the HIPAA special enrollment and claims and appeals filing deadlines will want to make sure that their plans are returned to their pre Covid state with respect to those deadlines. There's also some relatively recent IRS guidance regarding mid-year election changes that permits employees to revoke family coverage to allow the employee's family members to enroll in Affordable Care Act marketplace coverage. This guidance was really intended to plug a gap in the mid-year status change rules and plan sponsors who intend to permit mid-year election changes to the maximum extent permitted by the code will likely want to amend their cafeteria plans to include that additional mid-year election change event.

Lydia Parker:

I think if plan sponsors have generally been keeping their plans up to date from year to year. Those are the two that are still impacting everybody. So other than year-end amendments, anything else that plan sponsors should be aware of?

Lynne Wakefield:

Yeah, I guess another one I would mention is the CAA Gag Clause attestation that's due at the end of the year. That's one that may catch some plan sponsors by surprise because there hasn't been a lot of guidance yet and there hasn't been a lot of talk about it in the readings. But basically, the Consolidated Appropriations Act amended the code in ERISA to prohibit group health plans and health insurance issuers from entering into agreements with healthcare providers, networks, third party administrators and other service providers offering access to a provider network that would directly or indirectly prevent the plan or the insurer from disclosing certain provider specific costs, quality of care and other information to plan sponsors, to participants, to referring providers.

Those types of contractual provisions are referred to as gag clauses and plan sponsors are first required to submit an attestation with CMS that they do not have any contracts that contain those gag clauses, by December 31st of this year. After this year, this is an annual attestation, so it's going to be required every following December 31st. From what we can tell at this point, the submission of the attestation itself seems pretty straightforward. But famous last words, right? The more difficult task, I think is figuring out whether contracts actually have any of the impermissible gag clauses, particularly given that the guidance is not abundantly clear what a gag clause is.

Lydia Parker:

Right, exactly. And I completely get that right. It's hard for plan sponsors to get comfortable making an attestation with the government that they don't have any gag clauses when it's not clear what a gag clause is. Definitely seen some questions on that, and Lynne, I know we've discussed that one potential way around this is to include an override in your services agreements with TPAs to basically say nothing in this agreement will be construed to prohibit the plan from engaging in any of the activities described in that statute.

Lynne Wakefield:

Yeah, that makes sense to me. In the absence of additional guidance, I think it's about the best you can do. And it also seems like at least for the clients that we've been working with, the TPAs are expecting this center equipped to deal with it. So we've seen the TPA is willing to make this kind of an attestation, either in the services agreement itself or at least via an email confirming that nothing's going to be construed as a guide clause. I think that's a good starting point. Is there anything else arising out of the No Surprises Act, Lydia, that plan sponsors need to be focusing on or looking at in 2024?

Lydia Parker:

I can think of a couple of things. We have the annual prescription drug reporting, which is due by June 1st, 2024, but this is the third reporting cycle at this point, so hopefully that's pretty routine by now. The self-service tool is another one, and that's going to be expanded in 2024. And just for listeners who may not be super familiar with that one, this is a requirement in the CAA that requires plans to make certain information about call sharing, including an estimate of an individual's call sharing liability for covered items or services provided by a particular provider available on an internet-based self-service tool. And this is supposed to allow participants and beneficiaries to obtain an estimate and understanding of their out-of-pocket expenses for services. So as of 1/1/2023, 500 shoppable services had to be included in that tool. But all shoppable services have to be included in that tool as of 1/1/2024.

Lynne Wakefield:

I think it's important to note here that although a lot of plan sponsors are relying on TPAs to meet this requirement, under the rules, really that's only permitted for self-insured plan sponsors if that obligation is reflected in writing. So it's probably a good idea for self-insured plan sponsors to double check services agreements with their TPAs and make sure that this allocation of responsibility is addressed. Also, I think regardless of whether you're self-insured or fully insured, it's also worth a check-in with the TPA or insurer to make sure that the self-service tool is being updated to include all of the shoppable services.

Lydia Parker:

And I think both of those things, both the services agreement or having something in writing kind of obligating the TPA to comply and just generally reviewing your TPA to make sure that this is compliance that also applies for the machine-readable file requirement, or the MRF requirement, which probably warrants another quick update.

If you remember, when there was a flurry of activity to make sure MRFs were posted on a publicly available website, back in June of 2022 for a July 1st, 2022 enforcement effective date, only two of the three types of required information were at play. So plan sponsors were making sure MRFs covering in-network rates for covered items and services and allowed amounts for covered items and services furnished by out-of-network providers, those two were ready to go.

The third type of required information for negotiated rates and historical net prices for covered prescription drugs was still not being enforced. So that wasn't really a focus of plan sponsors. But the agencies announced, in September of 2023, that they were revoking the non-enforcement policy for that information. So prescription drugs are now at play, but they also did note that they intended to issue guidance with an implementation timeline. So there's a little bit of time on that one for plan sponsors to get ready.

Lynne Wakefield:

Yeah. Well, that's good. At least there's a little time to get ready for that one. I think in the same guidance, the agencies noted that they would immediately begin enforcing the requirement, that in-network rates be expressed as dollar amounts for items and services that aren't able to be reported as dollar amounts in advance. So that one's a little bit more pressing. But that's a lot

about the No Surprises Act. Maybe we can switch gears and see if there are any kind of trends or themes from a health and welfare plan design perspective that you've been seeing with clients.

Lydia Parker:

Yeah. And some more interesting ones too, which I think is always good, one thing that's come up several times is the exclusion of weight loss drugs for medical and prescription drug coverage, and also exclusion of gene therapy. Have you been seeing that?

Lynne Wakefield:

Yes, that has been a really interesting development. I feel like everyone has heard about the explosive use of the traditional diabetes medications, like Ozempic, being used for weight loss. If you aren't closely involved with the group health plan, though you may not appreciate just how much these drugs are increasing the cost of prescription drug coverage when those drugs are covered for weight loss.

Gene therapy may not be on everyone's radar. This is a type of treatment whereby a gene is delivered to a targeted tissue in the body, and it can be really effective to treat unusual ailments, like hemophilia or leukemia. It's usually a one-time, very expensive treatment, but it can offer a true cure for those types of diseases. But regardless, both items can be really expensive for a plan to cover, and so some plan sponsors have been talking about excluding them from coverage altogether.

Lydia Parker:

And then the question for us is, is that legally permissible? Can we just have a flat-out exclusion? And at this point, at least for self-insured larger group health plans, it seems the answer to that is yes, you can exclude these types of drugs, you have that flexibility from a legal perspective. But this design is likely going to be controversial with employees and it could give rise to litigation risk. And that's especially true if you think about the fact that the people who need these drugs or want these drugs may have significant health concerns. Especially for gene therapy, they may have highly sympathetic facts. Given the high cost of the drugs, a lot of these people are not going to be able to afford the drugs out of pocket. So given all of that, I think litigation is definitely all on plan sponsor's mind. So what about you? What are some of the health and welfare design trends you're seeing with clients?

Lynne Wakefield:

I continue to see plan sponsors interested in family planning or family formation type benefits around things like adoption, surrogacy and fertility and infertility benefits. There are a number of different ways to structure these types of programs, but there are also a number of different compliance considerations given that fertility and infertility benefits constitute medical care for internal revenue code purposes. There are also a number of different vendors out there that are marketing these types of programs now. Based on the designs that we've looked at, I think at this point, the best way to do this is to offer the fertility and infertility benefits through a preexisting medical plan and then to structure the adoption and surrogacy benefits around that.

If you're not able to do that, if your TPA doesn't have a mechanism for covering the fertility or infertility benefits, or if you're fully insured and you can't do it through the insurance, it doesn't mean that you can't do it, it's just that there are additional compliance considerations due to the ACA, you may have to implement an integrated HRA to avoid those ACA compliance concerns. It really adds a layer of administrative complexity. So it's one of those things where the providers that are out there in the market, they offer these types of benefits and you think, oh, that sounds good, that's easy enough. But you have to really look under the hood and think about, critically, what makes the most sense and how do we make this work.

Another thing, I guess I would mention, it's not necessarily a design feature, but it's the mental health parity issues, and in particular, the non-quantitative treatment limitations, or the NQTL comparative analysis. I continue to get questions from plan sponsors about how to address this requirement in a way that's compliant. And now we have the new proposed regulations that are intended to help with that. What do you think about the proposed regs? Is there anything helpful in there for plan sponsors with guidance on how to address this requirement?

Lydia Parker:

Helpful might be a strong word. I think you know how I feel about the proposed regulations. And hopefully, none of our listeners have had to trace through them as thoroughly as we have. It's incredibly complex. If anyone's interested in diving deeper into those, Lynne and I wrote an article we're happy to share with you on these proposed regs. So feel free to reach out. But if you haven't been thinking about how your plan complies with mental health parity, I'd say it's time to start. It's a very important focus of the DOL, and based on what we've seen, it's something that they're looking at in almost every health plan audit, even if the audit isn't even geared towards mental health parity. I know we're running short on time. Just generally, is there anything else you think we need to address? Lynne?

Lynne Wakefield:

I feel like we could talk about health and welfare forever, but there are a few things that I'll mention just briefly. The first one, and this one may have been overlooked by some of the listeners, but the agencies issued proposed regulations a few months ago regarding fixed indemnity insurance, like hospital indemnity, critical illness indemnity and accident indemnity type coverage. And if finalized, those proposed regulations will include additional compliance requirements that have to be satisfied in order for these types of benefits to be considered HIPAA accepted benefits and the regulations also clarify the tax treatment for those types of programs.

Lydia Parker:

And I know those plans have become more and more popular in recent years, so it's going to be important for us to keep our eyes on that.

Lynne Wakefield:

I agree. I assume the insurers are working on this as the guidance develops. These are all insured products, but it's definitely important to be aware of.

Lydia Parker:

Speaking of things that it's important to be aware of, I think we have to mention that we're starting to see more litigation in the health and welfare plan space.

Lynne Wakefield:

Yeah, this is definitely becoming more prevalent, and I think we're going to continue to see this in the coming months and years. It's really like all of the claims that have been raised in the 401(k) and retirement plan space for years are starting to make their way to health and welfare plans. We've had the COBRA Notice litigation around for a while, and that's ongoing and increasing. For the most part, the COBRA Notice litigation case is settled. But settling the cases can cost millions of dollars, and so I think it highlights the importance of reviewing COBRA notices, making sure that they track the model notices and making sure that the vendors that you've retained to do COBRA administration are following the notice and timing requirements that are set forth in the regs.

We also saw an interesting case this summer where a plan sponsor sued a third-party administrator for their self-funded medical and dental plans alleging that the TPA breached its fiduciary duties and engaged in prohibited transactions. Really what the plan sponsor was alleging was that the TPA paid millions in provider claims that actually never should have been paid and wrongfully retained millions of dollars in undisclosed fees, and also engaged in misconduct related to claims processing. There were some allegations in the suit as well regarding the practice of cross plan offsetting, which has been a focus in recent years. That's an interesting case, I think, to follow in the health and welfare plan space.

Lydia Parker:

Yeah, definitely interested to see how that one plays out. I know we touched on this. I just feel like it's a general theme that we're seeing, that so many plan sponsors just rely on their TPAs for so many different things, but plan sponsors don't necessarily have visibility into exactly what the TPA a is doing,=, and this case just highlights why governance and monitoring your TPAs are so important in the health and welfare plan context, just like they are in qualified plan context.

Lynne Wakefield:

Yeah, and if the third-party administrator is liable for these actions, query whether participants would have a right of action against the plan sponsor for breach of fiduciary duty in failing to properly monitor the TPA. That's concerning as well.

Lydia Parker:

On that positive note, that's a good point to conclude our episode today, and we hope everyone found the insights we've shared valuable and helpful. But if you have any questions, if you need further clarification on any of the topics we talked about today, please don't hesitate to reach out. This episode is part of an ongoing miniseries. We've got more exciting content coming your way, so stay tuned for the next installment. And don't forget about our annual webinar coming up in September of 2024. There, we'll be exploring these topics and more, providing a

comprehensive look at the future landscape of employee benefits and exec comp. Thanks for listening.

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