Benefits Law Deep Dive for BHCG Members

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Topics for Today

- Gag Clause rule
- Form 1094 / 1095 update
- Braidwood case
- Expense substantiation / miscellaneous guidance
- Prescription drug coupons
- Abortion / gender-affirming care coverage
- Cross-plan offsetting
- IDR update
- Denial letter and out-of-network litigation
- MHPAEA update
- Other expected changes

Gag Clause Rule

- Gag clause reporting rule part of Consolidated Appropriations Act (“CAA”), enacted December 27, 2020
- Effective immediately
- But general confusion about what it required, so many in the Benefits industry did not do much
  - Many relied on the argument that a typical contract has a provision that both parties will follow all applicable law
  - And, since the law was applicable, the contract automatically “conformed” to follow the Gag Clause Rule, even if the contract had a different, more specific provision which violated the rule
  - Is that a tenable position to take still? Will discuss later

Gag Clause Rule

- What does it require?
- Modifications to Code, ERISA, and PHSA
  - So, applies to both private (ERISA-covered) and non-ERISA group health plans
- A “group health plan” cannot “enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict” the plan from receiving certain information
- “Group health plan”: Major medical plans definitely included (“smaller” plans like dental and vision excluded)

Gag Clause Rule

- Note that Gag Clauses can be anywhere (ASA, NDA, BAA, etc.)
- Under the Gag Clause Rule, the contract cannot directly or indirectly restrict the group health plan from:

  (1) Providing provider-specific cost or quality of care information or data

  (2) Through a consumer engagement tool or any other means

  (3) To referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries of the plan

Gag Clause Rule

- Contract also cannot restrict the plan from "electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan"
- "upon request and consistent with the privacy regulations promulgated pursuant to [HIPAA, GINA and the ADA]"
- "including, on a per-claim basis, (i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract; (ii) provider information, including name and clinical designation; (iii) service codes; or (iv) any other data element included in claim or encounter transactions"
- Some of that ((ii), (iii), and (iv)) may not be very sensitive. But (i) might be viewed as proprietary by TPA and PBM – but, does an employer care?

Gag Clause Rule

- In addition, a contract cannot prohibit the sharing of the data with a business associate, subject to the same HIPAA / GINA / ADA limitations
- No specific exception for “proprietary” or “trade secret” information, although the contract can contain “reasonable restrictions on the public disclosure of the information”
  - Who is included in the “public”? Other competing TPAs?
- Big question: Do the references to HIPAA / GINA / ADA mean that those are the ONLY limits which can be in a contract? Or are they merely EXAMPLES of limits which can be in the contract?
  - CMS guidance suggests that those are the only limits which can be in the contract

Gag Clause Rule

- For example, Mid-Size TPA has, historically, shared claims data with its employer clients. However, if the data will be sent to a consultant (or even a competing TPA, perhaps one which is replacing Mid-Size or auditing Mid-Size's prior work for a client), Mid-Size requires that the recipient and employer enter into a nondisclosure agreement ("NDA"). The NDA refers to HIPAA / GINA / ADA
- But the NDA also includes some terms (such as not using the data to compete with Mid-Size TPA) that have nothing to do with HIPAA / GINA / ADA
- Is that NDA illegal? Was it unlawful for Mid-Size to send out new NDAs with those terms, after December 27, 2020? Was it unlawful for a client of Mid-Size to sign such an NDA?

Gag Clause Rule

- Another unusual feature of the Gag Clause Rule: “A group health plan shall annually submit to the Secretary an attestation that such plan is in compliance with the requirements of this subsection.”
- A “Reporting Entity” will do the submission
- “Reporting Entity” starts out as the group health plan. But TPA / PBM / behavioral health provider can act on its behalf
- Did your TPA / PBM / others do the reporting for you?
- Did you remove all Gag Clauses before submitting? If not, likely should get this “cleaned up” in 2024 (and try to rely on “required by law” provision for now)
- What about the contracts between the TPA and the providers?
- Special rule for fully-insured plans: not liable for the report if insurer does it
  - We think most insurers will do it. But good idea to discuss it

New Independent Contractor Rule

- On January 10, 2024, the DOL released its long-anticipated final regulation on how to determine if someone is an “employee” or an “independent contractor” for Fair Labor Standards Act purposes
  - Will take effect on March 11, 2024, unless litigation pauses it (and litigation is expected)
- 1947 U.S. Supreme Court decision identified six relevant factors
  - Opportunity for profit or loss depending on managerial skill; investments by worker / employer; degree of permanence of work relationship; nature and degree of control; extent to which work performed is an integral part of potential employer’s business; skill / initiative
- 2021 proposed rule would have emphasized two of these (nature and degree of individual’s control over the work and opportunity for profit / loss)
- New rule de-emphasizes these two
- Net takeaway: Likely take a look at how you define who is an independent contractor for benefit plan purposes; a change will not necessarily be needed

Form 1094 / 1095 Updates

- ACA requires that certain health plan coverage be reported to IRS annually
- Through Forms 1094 / 1095
- 1094-B and 1095-B filed if employer provides “minimum essential coverage” (typically, insurers and self-funded employers)
- 1094-C and 1095-C filed if employer is a “large” employer (typically, 50+ full-time or full-time equivalent employees)
- As a reminder, “good faith relief” from penalties recently expired
  - So, make sure that reporting is accurate, or large penalties could apply
- October 2023: IRS releases new Forms 1094 / 1095
- Main change: If filing at least 10 forms, must do so electronically (prior: 250)
- Penalty for failing to do so is $310 per form
- Dec. 2023 regulations: no penalty for incorrect $ amount, if $100 or less (and if employee did not “opt out”)

Braidwood Case

- Federal judge on March 30, 2023 ruled that certain preventive care benefits mandated for non-grandfathered health plans under the ACA should be vacated
  - Nationwide stay, so big impact (even though court in Texas)
- Initial mass confusion about what this meant
- DOL issued FAQs in April 2023 clarifying in part what the decision meant (trying to distinguish between recommendations made prior to ACA's effective date of March 23, 2010, versus those after; also focus on which entity made the recommendation)
- May 15, 2023: Fifth Circuit temporarily stayed the nationwide injunction (many filings were due in October 2023, but no decision yet)
- So, for now, no change, but employers should monitor this

Expense Substantiation

- On April 28, 2023, IRS issued Chief Counsel Advice on claims substantiation for health care flexible spending accounts ("Health FSAs") and dependent care assistance programs ("DCAPs")
- Expenses must be fully substantiated, regardless of the amount of expense
- Failing to do that means that benefits may be includable in employee's wages and subject to taxes (*e.g.* FICA and FUTA)
- Variety of non-compliant methods discussed:
  - Sampling of expenses
  - Certification by favored providers
  - No substantiation for small-dollar claims (*e.g.* a $5 minimum does not work)
  - Relying on debit cards (*e.g.* not ok to not substantiate debit card reimbursements that are charged for specific providers or hospital systems)

Miscellaneous New Guidance

- IRS Notice 2023-37 (June 23, 2023) – Provides clarification on certain COVID and preventive care benefits
- Prior COVID relief allowed high deductible health plans ("HDHPs") to cover COVID-19 testing and treatment on a pre-deductible basis
- The relief goes away for plan years ending on or before December 31, 2024
- So, employers may need to change this in 2024 (i.e., not allow it for 2025)
- Air ambulance reporting delayed
  - Part of CAA 2021
  - Will require reporting of some detailed information
  - TPAs will likely need to provide information
  - Will employers ask TPAs to do this reporting?

Prescription Drug Coupons / Copay Maximizers

- Copay maximizer litigation ongoing
  - Johnson & Johnson has brought a lawsuit against SaveOn; Abbvie sued Payer Matrix
  - If employer uses this type of program (where the deductibles and out of pocket payments vary based on third-party support) should probably revisit it
- New court decision, HIV and Hepatitis Policy Institute v. HHS (September 2023) creates confusion on coupons and drug manufacturer assistance: does it "count" towards an enrollee's deductible and out-of-pocket maximum?
  - *E.g.*, drug manufacturer provides Ed the Employee $5,000 coupon towards expensive drug. Good Co. health plan has **$3,000** deductible and $5,000 out-of-pocket max. Has Ed satisfied his deductible and OOP max?
  - Seems unlikely. Ed did not directly pay the $5,000. Also would contradict prior IRS guidance in HSA / HDHP context. But some uncertainty
  - Problem for health plans too. If the answer is that Ed hit his deductible and MOOP, will your TPA know that? How?

Abortion and Gender-Affirming Care

- Dobbs v. Jackson Women’s Health Organization overrules Roe and Casey
- No right under U.S. Constitution to any abortions, at any time
- So, total bans; 6-week bans; 15-week bans, etc. possible
- Some state laws are very old – *e.g.*, Wisconsin’s is from 1849; Texas has one from 1925
  - Many pre-date health plans or ERISA
  - So, applying old laws to 2022 health plans will not be easy or clean
- Some state laws impose civil penalties
  - *e.g.*, Texas “$10,000 bounty” law
- Others impose criminal penalties
  - Could also lead to loss of license in multiple states

Abortion Coverage

- Additional wrinkle: state laws can be enforced by local prosecutors
- Each county in a state may have its own local prosecutor
  - Texas has 254 counties. Potentially many different interpretations of Texas law
  - Will some local, elected prosecutors, in some states, want to be the “tough on abortion” prosecutor? Who “goes after” “out-of-state/foreign companies” that “aid or abet” in providing abortions?
  - Number of counties (and local prosecutors) is in the thousands
  - In Wisconsin, Attorney General Josh Kaul has said he will not enforce Wisconsin’s 1849 ban
  - However, on June 29, 2022 Sheboygan County DA Joel Urmanski said that he will enforce the 1849 law (first in WI to say that, apparently)
- Not to make it more complicated, but dozens of local (usually small) towns have gone beyond state law and banned abortion
  - *e.g.*, November 2022, Abilene Texas voters approved an ordinance declaring abortion “an act of murder unless the mother’s life is in danger”
  - Over 4 dozen towns and cities have passed these types of laws

Abortion Coverage

- ERISA Section 514 has strong preemption provisions, in general
- State laws usually preempted if "reference to" or "connection with" the plan
- Texas has a civil penalty which applies to a person who "knowingly engages in conduct that aids or abets the performance or inducement of an abortion, including paying for or reimbursing the costs of an abortion through insurance or otherwise"
- Would that reference to plan activities ("paying" or "reimbursing") "relate to" a plan and mean that ERISA would preempt this provision?
  - Likely yes

Abortion Coverage

- However, ERISA generally does NOT preempt criminal laws of general applicability
- So, need to look at how "general" the law is
- Alabama law: "Any person who…aids, abets or prescribes for [a non-life-of-the-mother-saving abortion] shall on conviction be fined not less than $100.00 nor more than $1,000.00 and may also be imprisoned in the county jail or sentenced to hard labor for the county for not more than 12 months."
- No reference to the plan or activities. Seems like a "general" criminal law, unlikely to be preempted by ERISA

Abortion Coverage

- July 7, 2022 letter from “Texas Freedom Caucus” (a group of Texas politicians) to Sidley Austin (a law firm based in Chicago, but with a Texas office) notes published reports that Sidley will pay for travel expenses for Texas employees
  - Group argues that this violates Texas law, which imposes criminal penalty on anyone who “furnishes the means for procuring an abortion knowing the purpose intended”
  - Claims it applies to “drug-induced abortions if any part of the drug regimen is ingested in Texas, even if the drugs were dispensed by an out-of-state provider”
- Aug. 2023: Alabama AG Steve Marshall argues in court filing that AL can bring criminal action against people who organize travel for those leaving AL to obtain an abortion: “criminal conspiracy”
  - Argues that conspiracy occurs in AL
  - Could an employer be viewed as part of that “criminal conspiracy” if it paid for travel expenses?
- Law is surprisingly unclear on whether a state can punish activities which occur outside of the state
  - 1941 Supreme Court case on sponge diver off Florida coast (Skiriotes v. Florida, 313 U.S. 69)

Abortion: Taxes and Labor Law Issues

- Could a state provide that its tax code does not "mirror" federal tax code? The idea is that state does not want to "subsidize" cost (through tax deduction) of abortion expenses
  - Almost certainly yes, the state could do that
  - *e.g.*, some states like New Jersey still do not follow tax treatment of health savings accounts ("HSAs"), in general
- At least one state, Kansas, makes abortion-related health benefits taxable at the state level (not the federal level)
  - Seems to have required (since about 2013) that health FSA, HRA, health plan treat abortion-related reimbursements as taxable
- Oct. 2023: West Allis, WI Starbucks location violated labor law by threatening to take away abortion travel benefits because employees wanted to unionize

Gender-Affirming Care Restrictions

- Many self-funded group health plans cover gender-affirming care
- Can include both surgical and non-surgical treatments
- Many plans follow guidance (at least as a starting point) from WPATH or similar third party organizations
- In the past few years, though, 19 states have enacted laws which place limits on such care
  - Alabama; Arkansas; Arizona; Florida; Georgia; Idaho; Indiana; Iowa; Kentucky; Mississippi; Montana; Nebraska; North Dakota; Oklahoma; Utah; South Dakota; Tennessee; Texas; West Virginia;
- That is especially true for procedures involving minors

Gender-Affirming Care Restrictions

- Restrictions usually apply to medical providers not payors / plan sponsors
- E.g., Arkansas' law (Senate Bill 199) states that it is "medical malpractice" for a provider to perform a "gender transition procedure" on a minor
- Is there some theoretical risk that a plan could be viewed as "aiding and abetting" – similar to the Texas Freedom Caucus threat?
- Chloe Cole, 18 years old, sent a notice in 2022 indicating that Cole would be suing both the providers and the Kaiser Foundation Health Plan
- But actual complaint dropped Health Plan and focused on Kaiser Foundation Hospitals and Permanent Medical Group, along with physicians who performed the care
- Basic argument is that there was medical negligence / malpractice
  - E.g., claim that, as a minor, Cole could not consent to the treatment. Are employers at risk if their health plan pays claims for minors who undergo surgeries which cannot be altered?
  - But don't employers do that all the time for "non-politically-controversial" surgeries?

Gender-Affirming Care Restrictions

- In related news, in 2022 Blue Cross Blue Shield of Illinois was sued under ACA Section 1557 when it was acting as a TPA
  - Employer plan did not cover transgender teenager’s gender-affirming care
- BCBSIL claimed that it should not be liable for client’s plan design
  - And that employer is not subject to 1557, so BCBSIL should not be when it administers the plan
- So far, court decisions have disagreed (but ongoing)

Cross-Plan Offsetting

- Mixed cases on the practice
- Involves a situation where TPA / insurer “overpays” an out of network provider on behalf of Plan #1 (e.g., by $1,000). TPA has no easy way to recover the $1,000
- So, when TPA processes claim for Plan #2 and an enrollee in Plan #2 uses that provider, TPA pays provider $1,000 less than what provider should be paid
- In 2021, UHC succeeded in a case because plaintiffs could not prove they were harmed
  - DOL amicus brief claimed that CPO was a breach of ERISA (cannot use assets / authority of one plan to benefit a different plan, basically)

Cross-Plan Offsetting

- However, Aetna lost a case in New Jersey
  - Court held that Aetna breached ERISA fiduciary duties
- Note: Practice far more common among TPAs that are also insurers
  - Because the "Plan #1" which benefits could be the fully-insured policy of the insurer / TPA, so insurer has financial incentive to encourage the practice (or even favor its fully-insured business)
- Sept. 2023: DOL enters into settlement with EmblemHealth for using CPO
- Requires Emblem to publicly post letter and repay any amounts participants may have been balance-billed
  - Does not seem to require Emblem's employer clients to pay these amounts – but is that next?
  - Net takeaway: Out-of-network CPO is definitely risky. In-network CPO is much safer, if TPA / provider contract supports it

IDR Update

- CAA requires "independent dispute resolution" ("IDR") process for certain CAA claims
- Fair amount of litigation as providers and health plans fight over structure and how IDR entities will determine qualifying payment amount ("QPA")
- Providers have been successful in many lawsuits
- Oct. 2023: CMS proposes new regulations on how IDR process will work. Additional guidance after that too (as recently as the past week)
- Net takeaway: TPAs may be charging more for IDR services, as it has become more complicated

Denial Letter Litigation

- Still a lot of litigation over denied mental health claims
- TPAs and group health plans have mixed results in cases, in general
- One important factor in favor of TPAs and group health plans is ensuring that plan's decision receives "deference" and that decision-maker has "discretion" to decide claim
- Plan documents should have this language (and should have for a long time now)
- Without discretion, court reviews situation "de novo" and can substitute its own judgment
- That is bad for plans, as many of these cases involve sympathetic plaintiffs and situations

Denial Letter Litigation

- Recent case from the 10th Circuit imposes stringent requirements on plans, in terms of what the denial letter must say
  - D.K. v. United Behavioral Health (10th Cir., May 15, 2023)
- Case relates to United's denial of proposed, lengthy residential treatment facility stay
- Enrollee, a teenage girl, was said to need 8-18 months of residential treatment, backed by treating physician's written recommendations
  - United approved lesser stays
- Plaintiff's attorney seems to have had a strategy of showing that United failed to follow ERISA's procedural rules on what should be in a denial notice. Apparent goal was to find technical error, then have court review claim de novo, with no deference to plan's decision

Denial Letter Litigation

- ERISA does impose some stringent requirements for denial notices
  - They must "provide adequate notice in writing … setting forth the specific reasons for such denial" and must "affordable a reasonable opportunity … for a full and fair review"
- United defended by saying that it was "not required to engage with treating physician opinions"
  - And, even if it was, just because the record does not mention them in writing does not mean that they were ignored
- Court found that United "specifically declined [the enrollee's] parents' request to consider extensive treatment opinions" from four doctors
- By not addressing these four doctors' opinions, seemingly on a point-by-point basis, United was not properly "'engaging' with these opinions" and United effectively "shut its eyes" to "readily available medical information"
- Thus, United "acted arbitrarily and capriciously"

Denial Letter Litigation

- Court also said that United needed to "engage in meaningful dialogue" as part of "full and fair review"
- Court expected to see a "back-and-forth", which is "how civilized people communicate with each other regarding important matters"
- At that point, court applied de novo review and found in favor of enrollee
- What's the takeaway?
  - Maybe it's just a 10th Circuit issue? Will this type of stringent requirement spread?
  - Maybe denial letters should acknowledge that all doctors' opinions were reviewed and considered? But is that really a "meaningful dialogue"?
  - Does the court want to see an explanation of why each doctor's opinion was, in essence, "overruled" by the plan's own opinion?
  - Perhaps some TPAs already have this type of point-by-point denial in all denial letters (if so, not a big deal for that TPA). Should employer raise it with TPA / PBM?

Out of Network Lawsuit

- Popovchak v. UHC (S.D. N.Y. Sept. 2023) – Lawsuit brought by plaintiff's firm (Cohen & Howard among the firms)
- Claim by health plan enrollees that plan fiduciaries violated ERISA fiduciary duty rules by failing to ensure that providers received adequate reimbursement and waived balance billing claims against plan enrollees
- Related to out-of-network ("OON") claims
  - Typically, vast majority of health plan claims are in-network. So total $ amounts at issue will be low, as a percentage, for most health plans … but still could be risk
- Because claims are OON, no contract. UHC (and other TPAs) sort-of "unilaterally" determine what to pay; pay the provider; then hope that the provider accepts it
- Court found that UHC "represented that they would negotiate discounts" with OON providers
- But that the OON providers "did not agree to accept discounted fees"

Out of Network Lawsuit

- As a result, OON provider could balance bill the enrollee
- But, plaintiffs alleged that UHC took a "shared savings" fee as though it had actually negotiated a discounted rate with the OON provider
- E.g., suppose the provider billed $36,000 for a procedure. UHC initially determines that $24,000 is payable. But then it uses a different database and determines that $18,000 should be paid. So it pays the provider $18,000
- A bit unclear, but it seems that UHC could take a % (33%?) of the "savings" of $6,000
- Plaintiffs claimed this violated UHC's duty of loyalty and "enriched" UHC
- Lawsuit against plan sponsor seems straightforward
- Recommend looking into this more with your TPAs (whether UHC or a different TPA, if they have a similar program)

Tax-Related Lawsuit

- On January 12, 2024, the DOL sued Blue Cross Blue Shield of Minnesota
- DOL claims that BCBSM, for its self-funded plans, it charged them a state-related tax AND that the ASA did not allow BCBSM to collect that tax (MinnesotaCare Tax)
- Tax seems to be owed by the providers, not the plans
- So, unclear why BCBSM imposed tax on the plans
- If you use BCBSM, talk to them about it
- If you use a different Blue Cross Blue Shield entity, would that entity have made you pay that tax also? E.g., when an employee traveled to MN and received services there?

Artificial Intelligence and Claims Processing

- Several recent lawsuits in Medicare Advantage space (NOT employer-sponsored group health plan space) claim that large insurers are improperly using AI to process claims
- Let’s define some terms first
- Algorithms v. “explainable” AI v. “black box” AI
- Frequently, health plan claims processing is automated. Generally not an inherent concern (and software, if well-designed, may be more accurate than human claims processors)
- ERISA concerns seem very possible with black box AI
- ERISA requires “full and fair review”. If TPA / plan sponsor cannot explain why AI reached decision it did (and cannot ensure that future, similar claims will be processed the same), seems like ERISA claim is possible

Artificial Intelligence and Claims Processing

- E.g., Lokken v. UHC (D. Minn. November 2023) is typical case
- Plaintiffs claim that UHC used AI to determine whether certain procedures were "medically necessary" under MA plan
- UHC developed the "nH Predict AI Model" to predict how many medical services the enrollee is expected to need (next slide)
- Plaintiffs claim that the AI had a "90% error rate" but profitable for UHC because only a small percentage (claimed to be 0.2%) will appeal the denial
- Plaintiffs claim that UHC employees cannot approve more than 1% variance in services, or risk being terminated or disciplined
  - Allegedly, without regard to what the doctor recommends for treatment / individual's specific situation
- Good idea to ask TPAs and PBMs if they use AI and if it is "explainable" or "black box". Build answers / representations into future contract terms

Acute

nH Predict | Outcome

Lucy Jones
DOB: 07/10/1926 Gender: Female
Admit Date: 01/05/2018

Patient Evaluation	Basic Mobility	Daily Activity	Applied Cognition	Total Average Score
Impairment Group: Stroke **Diagnostic Group:** CVA Occlusion Right Brain **Primary Dx:** I63.411-CEREB INFRC DUE TO EMBOLISM OF RIGHT MIDDLE CEREBRAL ARTERY **Usual Living Setting:** Home with Family **Medical Complexity:** 3 - Active, system disease limiting function **Grouper(s):** IV | Feeding Tube - NG	e.g. Transfers, ambulation, stairs, wheelchair skills	e.g. Bathing, toileting, dressing, eating (ADL/IADL)	e.g. Memory, communication, problem solving	Average of Basic Mobility, Daily Activity, and Applied Cognition scores
Acute Function Projected non-skilled caregiver needs post Acute	38 Max A to Mod A 3 Hours/Day	27 Mod A to Min A 3.75 Hours/Day	52 24/7 Supervision 24/7	39 Mod A to Min A 6.75 Hours/Day
Home Health Outcomes Prediction (+6 Avg. Gain) 11.9 avg. Therapy visits per episode Projected non-skilled caregiver needs post Home Health	45 Mod A to Min A 3.25 Hours/Day	36 Min A to SU/Supervision/SBA 2 Hours/Day	56 Close/Frequent Supervision Frequent	46 Mod A to Min A 5.25 Hours/Day
SNF Outcomes Prediction (+10 Avg. Gain) Consider Projected non-skilled caregiver needs post SNF	48 Min A to SU/Supervision/SBA 2 Hours/Day	41 Min A to SU/Supervision/SBA 0.75 Hours/Day	59 Close/Frequent Supervision Frequent	49 Min A to SU/Supervision/SBA 2.75 Hours/Day

Likelihood of Hospital Admission from SNF in less than 30 days: 34% (High)

Actual Discharge Setting After SNF

MHPAEA and CAA

- In December 2020, Consolidated Appropriations Act, 2021 (“CAA”) required plans to create a written comparative analysis
- To compare how stringently all the plan’s NQTLs are applied to M/S benefits compared to MH/SUD benefits
- In theory, needed it done by February 2021
  - In reality, probably no one had it done by then because unclear what needed to be in the analysis

NQTL Comparative Analysis (2021)

- Key term of “comparative analysis” not defined in CAA, although some details in CAA
- FAQs from April 2021 provided some insight
- Need to be able to provide a “robust discussion” of nine elements
  - But not really clear what it would “look like”

NQTL Rules (2023)

- Proposed regulations and other guidance from late July / early August 2023 is surprising
- Plan fiduciary must “certify” compliance
  - Sounds similar to Gag Clause attestation
- Clear that DOL wants to establish a “safe harbor” for network utilization / network adequacy
  - But not clear what data will “prove” that
- Largest change is that no NQTL could be imposed unless two-thirds and one-half test is satisfied

NQTL Rules (2023)

- Detailed example: Medical necessity determination is used under the plan for all inpatient, in-network benefits (M/S or MH/SUD). For all benefits in that classification, prior authorization is granted for 1 day, 3 days or 7 days
- For M/S benefits, approval for 7 days is the most common number. For MH/SUD, 1 day is the most common number of days approved as medically necessary
  - After time period is over, plan requires a treatment plan
- Time periods (7 days v. 1 day) are not the result of independent professional medical or clinical standards
  - Or standards used to detect or prevent fraud, waste or abuse
  - These are two "exceptions" which are now important

NQTL Rules (2023)

- Does the plan comply under the new regulations?
- First, check if 2/3 test is met
  - It is, as the medical necessity determination applies to 100% of the benefits in the classification
- Second, identify the most common or frequent variation of the NQTL
  - 7 days for M/S
  - 1 day for MH/SUD

NQTL Rules (2023)

- 1 day is more stringent than 7 days
- Thus, the “predominant” NQTL is applied more stringently to MH/SUD benefits compared to M/S benefits
- Thus, “the plan violates the rules” of MHPAEA
- What must plan do?
- Presumably plan must approve MH/SUD in that classification for 7 days; or limit M/S to 1 day
- Expect some guidance in first half of 2024. Hopefully the guidance is clear and “workable”

Other Expected 2024 Changes

- May see long-awaited EEOC “wellness program” regulations
- Likely will have new cases on whether gender-affirming care (e.g., gender transition surgery) must be covered by Section 1557 / Civil Rights Act
- Will U.S. Supreme Court “gut” Chevron doctrine? Will that be “bad” for employers? Or good?
- Federal TPA law is possible
  - Will it cut back on ERISA preemption and allow states to regulate? That would probably be “bad” for employers
- Happy 50th birthday ERISA! (Enacted September 1974)

Questions?

Thank You!

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