M | M | P | L

EMPLOYEE BENEFITS LAW

Legal Developments Impacting Health & Welfare Plans

2021 Year-End Update

1. Various regulations and guidance from the HHS, DOL, and the Department of Treasury (the Departments) address implementation of the **surprise billing rules and transparency regulations** under the Consolidated Appropriation Act, 2021 (CAA), which include a delay on enforcing certain requirements, such as advance explanations of benefits and prescription drug pricing disclosures. For more information on the enforcement delays, see our article.

2. The Departments confirmed that plans may offer a **premium discount for receiving a COVID-19 vaccination**—or impose a premium surcharge on the unvaccinated—so long as the plan complies with HIPAA's wellness program rules. For example, the discount or surcharge (when combined with any other wellness program incentives) cannot be more than 30% of the cost of coverage. However, a plan cannot condition eligibility for benefits on an individual's vaccination status.

3. In March 2020, the IRS and DOL **extended the deadlines for COBRA elections and COBRA payments** by up to a year during the coronavirus emergency period. Deadlines to file claims and appeals and enroll dependents mid-year after birth or marriage were similarly extended. In early 2021, further guidance clarified that the usual deadlines are extended for each participant deadline, up to a maximum of a year. Additional clarifying guidance in 2021 also provided additional time for certain initial COBRA elections and payments.

4. The American Rescue Plan Act of 2021 included several **temporary rules to address the COVID-19 pandemic**, including a COBRA subsidy, increased Dependent Care Assistance Program (DCAP) limits, and expanded Affordable Care Act (ACA) premium tax credits for those who purchase Exchange coverage.

5. As we've previously reported, Congress eliminated the individual mandate penalty of the ACA in 2017, leading a federal district court to find the entire **ACA unconstitutional**. In June 2021, the Supreme Court dismissed the case on procedural grounds.

6. The CAA amended the Mental Health Parity and Addiction Equity Act (MHPAEA) to require that plans conduct a **comparative analysis of the non-quantitative treatment limitations** (NQTLs) applicable to mental health or substance-use disorder benefits. Although there is still significant uncertainty around the level of detail required in these comparative analyses, agency guidance provides some clarity on their necessary substance and documents subject to disclosure. The DOL has begun requesting NQTL documentation from certain plans and insurers, and the Departments issued a report in January 2022 stating that insurers and plans are "falling short" in MHPAEA compliance.

7. **Litigation under the MHPAEA** continues. One court ruled a plan's exclusion of intensive behavioral therapies such as Applied Behavior Analysis violated the rules on NQTLs.[i] Another court found an NQTL violation where a plan required medical necessity for all coverage but also imposed additional criteria to determine medical necessity for mental health benefits.[ii] The DOL also announced a $15.6 million settlement with an insurer which, the DOL alleged, had several practices which reduced reimbursement rates for out-of-network mental health services and flagged participants seeking mental health treatment for utilization review.

8. The Departments issued joint guidance clarifying that **HIV PrEP antiretroviral medication is preventive care** under the ACA and must be covered without cost-sharing. The new guidance clarifies that plans must also cover without cost-sharing other items and services the United States Preventive Services Task Force (USPSTF) recommends before an individual is prescribed anti-retroviral medication, as part of the determination of whether the medication is appropriate and for ongoing follow-up and monitoring. Plans may apply medical management techniques, but only to the extent the USPSTF recommendation does not specify the frequency, method, treatment, or setting for the provision of HIV PrEP services.

9. Courts continue to flesh out how HHS regulations on the **ACA § 1557 rule against discrimination in healthcare** apply to employer-sponsored health coverage, including the prohibitions on sex discrimination. Although portions of the 2016 and 2020 versions of the § 1557 regulations remain enjoined by court order, HHS announced it will interpret the statutory text to prohibit discrimination based on sexual orientation and gender identity consistent with the Supreme Court's 2020 decision in *Bostock v. Clayton County*. The Biden administration is expected to overhaul the 2020 regulations.

10. The Fourth Circuit allowed a case to proceed against Aetna for passing a subcontractor's **administration fees bundled together as part of medical providers' actual** costs to its client, a plan, and the plan's participants. Plaintiffs alleged that passing through the bundled fees (which plaintiffs described as accomplished through "dummy codes") resulted in a prohibited transaction.[iii] The court agreed that if Aetna is found to be a fiduciary, this arrangement would be a prohibited transaction. Aetna is seeking Supreme Court review of this decision.

11. Following a 2019 court ruling which called into question a third-party administrator's (TPA's) practice of underpaying claims to providers for one plan to recoup *another* plan's prior overpayments to the same provider—described as "**cross-plan offsetting**"—courts have begun to address the propriety of this practice under ERISA. In one case, which also aligns with the DOL's position, a federal district court ruled cross-plan offsetting was an ERISA prohibited transaction and violated the TPA's fiduciary duties.[iv] The TPA in that case is appealing that decision. Another district court dismissed a similar challenge on procedural grounds, leaving open the substantive questions about the practice's ERISA compliance.[v]

12. The DOL issued guidance that the **voice recording of a call between a claimant and an insurer's representative** relating to an adverse benefit determination was relevant

information subject to disclosure upon request under ERISA's claim procedure. Rejecting the insurer's argument that only the transcript was disclosable because the recording made solely for "quality assurance purposes" and not relied upon in deciding the claim, the DOL reasoned the recording was nevertheless subject to disclosure because it was generated during the claim determination and demonstrated compliance with the claim procedures.

13. The IRS issued two notices clarifying the relief for **health and dependent care flexible spending arrangements (FSAs)** provided under the CAA and ARPA.[vi] Among other items, they explained dependent care benefits available as a result of the CAA's carryover or claim extension relief that would have been excludible from income if used during the 2020 or 2021 tax years remain eligible from exclusion and don't apply towards the dependent care limits in later tax years. This is similar to existing law on health FSAs, which is clear that carried-over amounts do not count towards the health FSA contribution limit for a year.

14. The Departments announced that by February 2022, they will initiate rulemaking to amend the 2018 regulations that expanded the **religious and moral exemptions to the requirement that non-grandfathered plans cover contraceptives**. The Departments also released recent guidance in response to numerous complaints and reports that participants and beneficiaries are being denied coverage of contraceptives in violation of the ACA. The Departments cautioned plans and insurers that they must cover (without cost-sharing) all FDA-approved contraceptives deemed medically appropriate for an individual by the attending provider, even if not included in the FDA's Birth Control Guide.

15. In March, the Ninth Circuit issued **contrasting decisions regarding ERISA preemption**. In the first, the court decided claims were preempted, dismissing state-law claims of misrepresentation and fraudulent practices in an insurer's claim denial and reasoning that subjecting the insurer's decisions to state law would conflict with ERISA's exclusive regulation of benefit claim decisions.[vii] In the second, the court ruled ERISA does not preempt Seattle's Fair Share law—which requires either direct payments to certain hotel employees or payment of the same amounts on their behalf for health coverage—because employers can comply with the Seattle law through direct payment without affecting an ERISA health plan.[viii] The Supreme Court is currently considering whether to accept an appeal of the latter case.

16. The Fifth Circuit **overturned a $4+ million HIPAA penalty** that HHS assessed on a healthcare provider that lost several devices containing unencrypted patient data. The court determined the penalty was "arbitrary and capricious" for a variety of reasons, including HHS's failure to show that an unauthorized person actually accessed the lost data.[ix]

17. HHS continues to assess **penalties for HIPAA violations**, including a $5+ million settlement with a health insurer over data breaches resulting from a cyberattack that went undetected for over a year. HHS also assessed numerous penalties for failures to timely give individuals access to their health information.

18. The Supreme Court agreed to review whether a plan's **uniform reimbursement of all dialysis treatments as out-of-network** could violate the Medicare Secondary Payor

(MSP) rules due to its disparate impact on patients with end-stage renal disease. The Sixth and Ninth Circuits are split on this issue, with the Ninth Circuit holding MSP rules only prohibit express differentiation based on the existence of end-stage renal disease or the need for renal dialysis,[x] whereas the Sixth Circuit held a disparate impact theory is cognizable.[xi] The outcome of the Supreme Court's decision will significantly impact cost-containment plan designs related to dialysis benefits.

19. The **Patient Centered Outcomes Research Institute (PCORI) fee** increased from $2.66 to $2.79 per covered life for plan years ending after September 2021 and before October 2022. Payments are due by July 31, 2022.

20. For 2022, the ACA **out-of-pocket maximum** on in-network benefits cannot exceed $8,700 per person and $17,400 per family.

21. For 2022, the **annual dollar limit** on employee contributions to health FSAs is increased from $2,750 to $2,850.[xii] The limit on Health Savings Account (HSA) contributions for self-only coverage is increased from $3,600 to $3,650, and the limit for family coverage is increased from $7,200 to $7,300. The age 55+ HSA catch-up limit remains at $1,000.

From all of us here at MMPL, your employee benefits law firm.

Not intended as legal advice.

---

[i] *Doe v. United Behavioral Health*, 523 F. Supp. 3d 1119 (N.D. Cal. 2021).
[ii] *M. S. v. Premera Blue Cross*, No. 219CV00199RJSCMR, 2021 WL 3511094 (D. Utah Aug. 10, 2021).
[iii] *Peters v. Aetna Inc.*, 2 F.4th 199 (4th Cir. 2021).
[iv] *Lutz Surgical Partners PLLC v. Aetna, Inc.*, No. 315CV02595BRMTJB, 2021 WL 2549343 (D.N.J. June 21, 2021).
[v] *Scott v. UnitedHealth Group Inc.*, 540 F. Supp. 3d 857 (D. Minn. 2021).
[vi] See our article for more discussion on the CAA.
[vii] *Meyer v. United Healthcare, Insurance Co*., 840 F. App'x 174 (9th Cir. 2021).
[viii] *ERISA Industry Committee v. City of Seattle*, 840 F. App'x 248 (9th Cir. 2021).
[ix] *University of Texas M.D. Anderson Cancer Center v. U.S. Dep't of Health & Human Services*, 985 F.3d 472 (5th Cir. 2021).
[x] *DaVita, Inc. v. Amy's Kitchen*, 981 F.3d 664 (9th Cir. 2020) (holding that the MSP rules only prohibit express differentiation based on the existence of ESRD or the need for renal dialysis).
[xi] *Marietta Memorial Hospital Employee Health Benefit Plan v. DaVita Inc.*, 978 F.3d 326 (6th Cir. 2020), *cert. granted,* 142 S Ct. 457 (2021).
[xii] This is in addition to the temporary relief from the carryover limit described in our article on the CAA.