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EMPLOYEE BENEFITS LAW

Legal Developments Impacting Health & Welfare Plans

2022 Year-End Update

1. In June, the Supreme Court ruled the Constitution does not guarantee a right to abortion, leaving states free to regulate them.[1] This means **state law may dictate coverage of abortions** by insured health plans while ERISA plan sponsors may decide whether self-funded health plans will cover abortions. Limits on coverage will apply—for example, plans generally will not cover medical procedures that are illegal in the state where performed. Other issues remain open—for example, coverage of abortifacient drugs obtained out-of-state and reimbursement for out-of-state travel to obtain an abortion. Upcoming legislative sessions will likely produce additional laws.

2. Following the Supreme Court's abortion ruling in *Dobbs*, the HHS, DOL, and the Department of Treasury (the Departments) issued various forms of guidance to **bolster compliance with the Affordable Care Act's (ACA) existing contraceptive coverage mandate** for non-grandfathered plans as well as double-down on its enforcement.

3. HRSA guidelines **expanded women's preventive health services that must be covered** without cost-sharing in plan years beginning on or after December 30, 2022 including obesity counseling for women aged 40-60, electric breast pumps, the full range of contraceptives listed in the Food and Drug Administration guide, HIV screening and education, and well-woman visits.

4. The Supreme Court determined that a plan's **uniform reimbursement of all dialysis treatments as out-of-network** does not violate the Medicare Secondary Payor (MSP) rules, notwithstanding the disproportionate impact on patients with end-stage renal disease.[2]

5. A federal district court[3] ruled the United States Preventive Services Task Force (USPSTF) was **unconstitutionally appointed and thus has no authority to determine which preventive services** are covered by the ACA's preventive health services mandate, including the USPSTF's decision to require **coverage of HIV preexposure prophylaxis (PrEP)**. On the plaintiff-employers' claims under the Religious Freedom Restoration Act (RFRA), the court also ruled the USPSTF failed to show a compelling government interest in PrEP coverage or that requiring coverage is the least restrictive means to reduce the spread of HIV. The scope of this ruling is still uncertain.

6. In August, the Departments issued final regulations **to determine provider payments in arbitrations required under the No Surprises Act (NSA)**. Under the NSA, out-of-network providers can arbitrate disputes over the amount paid by a health plan for emergency services, non-emergency services provided at in-network facilities, and air ambulance services. A federal court had ruled that the Departments' earlier interim final regulations improperly gave preference to a health plan's "qualifying payment amount" (QPA) in these arbitrations.[4] The final regulations have removed the language disallowed

by the court, but a new lawsuit alleges the final regulations still improperly favor the plan's QPA.

7. The Departments also released a **technical assistance guide** and checklist for resolution of provider payment disputes and arbitration under the NSA, as well as a regularly updated **list of arbitration entities** authorized to decide provider payment disputes.

8. The Departments issued several pieces of **guidance on the NSA, Consolidated Appropriations Act of 2021 (CAA)**, and other related subjects. Included were: application of surprise billing protections of the NSA to plans without preferred provider networks; NSA payment levels for air ambulance services outside the United States; clarifications of the requirement that most health plans provide an online, personalized self-service tool for estimating the costs of services covered by the plan; and details regarding the requirement that health plans maintain machine-readable data files for out-of-network plan charges, in-network provider rates, and historical prices for prescription drugs. In separate CAA guidance, plans were required to report certain medical and pharmacy data by December 27, 2022, but in light of the challenges of timely compliance, the Departments are permitting plans to report through January 2023 and said no enforcement action would be taken against plans that report using a good faith, reasonable interpretation of the regulations and reporting instructions.

9. Under the CAA, entities providing **brokerage or consulting services to health plans** generally must **disclose direct and indirect compensation** related to those services, including any commissions, finder's fees, and any other transaction-based fees. The DOL has not issued regulations on this requirement but instead announced it will allow plan fiduciaries to comply through reasonable, good faith efforts, including by fee disclosure requests similar to those required for pension plans.

10. In the wake of the 2020 Supreme Court decision in *Bostock v. Clayton County*, numerous district courts have struck down health plan **exclusions of gender affirming care as prohibited sex discrimination**. While different laws have applied based on the type of coverage at issue (e.g., governmental plans, exchange coverage, or private employer-sponsored plans), courts have applied a similar rationale in each case. See our article for more detail.

11. In August, HHS proposed its third iteration of **regulations under ACA § 1557, which prohibits discrimination on the basis of sex** (and other protected characteristics) in healthcare. The 2016 and 2020 versions of the rule prompted a slew of lawsuits, resulting in ongoing injunctions against portions of both versions. The latest proposal would reinstate much of the 2016 iteration, notably including protections based on sexual orientation and gender identity consistent with the Supreme Court's decision in *Bostock*. The proposal would re-broaden the scope of covered entities to include health insurers receiving federal financial assistance, though it does not include the 2016 section which made the rule applicable to certain employers with respect to the benefits they offer their employees.

12. The Departments issued clarifying guidance that plans must generally cover the **cost of over-the-counter COVID-19 tests purchased without a prescription** during the ongoing COVID-19 public health emergency period without cost-sharing, prior authorization, or other medical management requirements, though plans that meet the safe harbors described in the guidance may impose certain quantity and reimbursement limits. While plans must also generally cover COVID-19 tests performed in-person, most courts have held that providers do not have a private right of action to sue health plans for reimbursement.[5]

13. The Departments issued a January 2022 report that insurers and plans were failing to produce satisfactory **comparative analyses of non-quantitative treatment limitations (NQTLs)** under the Mental Health Parity and Addiction Equity Act (MHPAEA). The DOL has continued requesting these analyses, purportedly working with plans and insurers to improve the analyses; however, significant uncertainty persists around the level of detail required.

14. The First Circuit found a plausible **MHPAEA violation where a plan covered rehabilitative speech therapy but excluded habilitative services**. The plan's coverage of rehabilitative care (such as restorative speech therapy) included both mental health and medical diagnoses, whereas the court viewed the exclusion of habilitative services as impacting only mental health diagnoses.

15. Under new IRS guidance, cafeteria plans may now permit prospective **midyear election changes from family coverage to employee-only coverage** (or from family coverage to family coverage that excludes a previously covered individual) for certain group health plans, so long as those dropped from coverage are eligible to enroll in a qualified health plan (QHP) through the Exchange and experience no resulting gap in coverage. Plans may rely on an employee's reasonable representation about enrolling in a QHP.

16. The Fifth Circuit vacated a DOL advisory opinion on the **ERISA plan status of a health insurance purchasing arrangement**[6] under which thousands of "limited partners"[7] could purchase health insurance through the partnership. The DOL opined insurance through the partnership was not a single ERISA plan because the individuals were not bona fide partners with self-employment income. The Fifth Circuit held the DOL's opinion was arbitrary and capricious, remanding the case to the district court to examine whether the participants should be considered "working owners" or "bona fide partners" under ERISA and relevant Supreme Court precedent.

17. HHS continues to assess **penalties for HIPAA violations**, including an $875,000 settlement with a medical center over its lengthy delay in reporting a data breach resulting from a cyberattack. The medical center was not initially aware it had health information stored on the compromised server. HHS also assessed penalties for failures to timely give individuals access to their health information.

18. New preventive care guidance from the Departments advises, among other things, that health plans and insurers **must cover colonoscopies, without cost-sharing,** after a non-invasive stool-based screening test or a direct visualization screening test for colorectal

cancer. The guidance is effective for plan or policy years beginning on or after May 31, 2022.

19. Federal courts are in conflict regarding whether a **third-party administrator (TPA)** making payments from an account funded by a self-insured plan has **fiduciary responsibility for plan coverage determinations**. Disagreeing with an earlier Sixth Circuit decision, a federal district court ruled a self-funded plan's monthly forwarding of plan funds to a TPA for making claims payments did not make the TPA an ERISA plan fiduciary based on its "management or control" of plan assets.[8] Therefore, the court ruled the TPA did not have fiduciary responsibility for alleged errors in its coverage decisions. The ruling has been appealed to the First Circuit.

20. Two recent cases highlight how **statements promising benefits beyond those stated in the plan** can be a **fiduciary breach**, requiring payment beyond what the plan or insurance policy allows. In one case, an employee elected an increase in long-term disability coverage, and her employer incorrectly described the change as a 60% *increase* in coverage, up to "100% of salary," beyond the maximum coverage level of 60%. The federal district court ruled this employer misstatement was a breach of fiduciary responsibility and that it—not the insurer—must cover the difference between the 60% promised by plan terms and the 100% level the employer had represented.[9] Similarly, the Eleventh Circuit ruled an employer breached its fiduciary responsibility, requiring it to provide $350,000 in supplemental life insurance when it processed payroll deductions and provided a statement indicating that the employee had enrolled in that coverage, even though the employee had submitted incomplete enrollment paperwork and had therefore failed to enroll.[10]

21. A federal district court held a health plan's **informational calls on the availability of free services could be seen as a pretext** to solicitation, thereby violating the Telephone Consumer Protection Act.[11] The court also ruled prior express consent is needed before a HIPAA-covered entity may use an automatic telephone dialing system or an artificial or prerecorded voice to leave health care messages on a cell phone.

22. A federal district court ruled that a plaintiff had a viable claim that her former employer **violated COBRA** where the employer **failed to notify the plan's COBRA Administrator of the former employee's address change**.[12] Although the Administrator was contractually responsible for sending COBRA notices and never informed the employer its COBRA election notice was returned as undeliverable, the court concluded the employer was statutorily responsible for the COBRA notices, which included making good faith efforts to ensure the Administrator had up-to-date contact information for employees. The court noted the Administrator might nevertheless be liable to the employer for breach of contract.

23. In February, HHS opened an online exchange between child support agencies and employers, TPAs, and plan administrators to allow for **electronic delivery of and responses to National Medical Support Notices (NMSNs)**, which are used by state child support enforcement agencies to obtain group health coverage for children. In guidance, HHS noted the benefits of participating in this voluntary system, such as: quicker delivery

of NMSNs and updates to child support status; increased reliability of information; reduced time and cost of responding to NMSNs; and earlier coverage for children in need.

24. The **Patient Centered Outcomes Research Institute (PCORI)** fee increased from $2.79 to $3.00 per covered life for plan years ending after September 2022 and before October 2023. Payments are due by July 31, 2023.

25. For 2023, the **ACA out-of-pocket maximum** on in-network benefits cannot exceed $9,100 per person and $18,200 per family.

26. For 2023, the **annual dollar limit** on employee contributions to health FSAs is increased from $2,850 to $3,050. The limit on Health Savings Account (HSA) contributions for self-only coverage is increased from $3,650 to $3,850, and the limit for family coverage is increased from $7,300 to $7,750. 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.

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[1] *Dobbs v. Jackson Women's Health Organization,* 142 S. Ct. 2228 (2022).
[2] *Marietta Memorial Hospital Employee Health Benefit Plan v. DaVita Inc.,* 142 S. Ct. 1968 (2022).
[3] *Braidwood Management, Inc. v. Becerra*, No. 4:20-cv-00283-O, 2022 WL 4091215 (N.D. Tex. Sept. 7, 2022).
[4] *Texas Medical Association v. U.S. Dep't of Health & Human Services*, 587 F. Supp. 3d 528 (E.D. Tex. 2022), *appeal dismissed per stipulation*, No. 22-40264, 2022 WL 15174345 (5th Cir. Oct. 24, 2022).
[5] *See, e.g., Saloojas v. Cigna Healthcare of California, Inc*., No. 22-cv-03270-CRB, 2022 WL 5265141 (N.D. Cal. Oct. 6, 2022) (no private right of action); *Betancourt v. Total Property Management*, No. 1:22-cv-0033 JLT EPG, 2022 WL 2359286 (E.D. Cal. June 30, 2022) (same); *Murphy Medical Associates LLC v. Cigna Health & Life Insurance Co.*, No. 3:20CV1675(JBA), 2022 WL 743088 (D. Conn. Mar. 11, 2022), *reconsideration granted on other grounds*, 2022 WL 10560321 (D. Conn. Oct. 18, 2022) (same). *But see Diagnostic Affiliates of N.E. Hou, LLC v. United Healthcare Services*, No. 2:21-CV-00131, 2022 WL 214101 (S.D. Tex. Jan. 18, 2022) (finding an implied private right of action).
[6] *Data Marketing Partnership, LP v. United States Dep't of Labor*, 45 F.4th 846 (5th Cir. 2022).
[7] The partnership produced and sold electronic data, and the "limited partners" had simply agreed to install and allow access to software that would capture and transmit data concerning their electronics usage.
[8] *Massachusetts Laborers' Health & Welfare Fund v. Blue Cross Blue Shield of Massachusetts*, No. 21-10523-FDS, 2022 WL 952247 (D. Mass. Mar. 30, 2022), *appeal filed* No. 22-1317 (1st Cir. May 4, 2022).
[9] *Johnson v. Ballad Health*, No. 2:21-cv-50, 2022 WL 214488 (E.D. Tenn. Jan. 24, 2022).
[10] *Gimeno v. NCHMD, Inc.*, 38 F.4th 910 (11th Cir. 2022).
[11] *Fiorarancio v. WellCare Health Plans, Inc.*, No. CV 21-14614 (SRC), 2022 WL 111062 (D.N.J. Jan. 11, 2022).
[12] *Howard v. Ivy Creek of Tallapoosa, LLC*, No. 320CV00213RAHSMD, 2022 WL 4390431 (M.D. Ala. Sept. 22, 2022).