Compliance Monthly Update: May 2024

A brief update on what happened the prior month in group health plan compliance at the federal level–organized chronologically. If you would like additional information, please reach out to the GBS Compliance Team.

FAQ guidance extends nonenforcement relief related to the No Surprises Act. On May 1, the DOL/HHS/IRS issued FAQ guidance Part 67 on calculating the qualifying payment amount (QPA) used in the independent dispute resolution (IDR) process under the No Surprises Act. This FAQ provides continued guidance after the 2023 case *Texas Medical Association v. HHS (TMA III)* vacated QPA calculation provisions in interim final regulations and related guidance. This new FAQ guidance provides an extension of enforcement discretion provided in prior guidance under FAQs Part 62 (discussed in our October 2023 monthly update), where the agencies advised that plans and insurers are expected to calculate the QPA using a good faith, reasonable interpretation of the No Surprises Act and the regulations that remain in effect after the *TMA III* decision.

Final rule issued to increase access to health care for DACA recipients. On May 3, HHS issued a final rule (along with an associated press release and fact sheet) implementing the Biden Administration's commitment to expand health care access for Deferred Action for Childhood Arrivals (DACA) recipients. Under this rule, DACA recipients will no longer be excluded from eligibility to enroll in Marketplace (i.e., Exchange) coverage or for coverage through a Basic Health Program (BHP). HHS estimates that this rule could lead to 100,000 previously uninsured DACA recipients enrolling in health coverage through the Marketplace or a BHP. HHS also made technical modifications to the definition of "lawfully present" used to determine eligibility for coverage through a Marketplace or a BHP.

2025 inflation-adjusted amounts for HSAs and HDHPs. On May 9, the IRS released the 2025 cost-of-living adjusted limits for HSAs, HDHPs, and excepted benefit health reimbursement arrangements (EBHRAs). These adjusted limited apply to plan years that start in 2025 – so, for HDHPs with non-calendar plan years, the adjusted limits for the calendar year in which the plan year begins can be applied for that entire plan year. Remember that the out-of-pocket maximums listed below are applicable to HSA-compatible HDHPs. Separate out-of-pocket dollar limits were previously announced for 2025 that apply to non-grandfathered non-HDHP plans (which is $9,200 for self-only coverage and $18,400 for family coverage).

- HSA contribution limits. The 2025 annual HSA contribution limit is $4,300 for individuals with self-only HDHP coverage (up from $4,150 in 2024), and $8,550 for individuals with family HDHP coverage (up from $8,300 in 2024). The catch-up contribution limit for HSA-eligible individuals 55 or older remains unchanged at $1,000.
- HDHP Minimum Deductibles. The 2025 minimum annual deductible is $1,650 for self-only HDHP coverage (up from $1,600 in 2024) and $3,300 for family HDHP coverage (up from $3,200 in 2024).
- HDHP Out-of-Pocket Maximums. The 2025 limit on out-of-pocket expenses (including items such as deductibles, copayments, and coinsurance, but not premiums) is $8,300 for self-only HDHP coverage (up from $8,050 in 2024), and $16,600 for family HDHP coverage (up from $16,100 in 2024).

- EBHRA Contribution Limit. The maximum amount that may be made newly available for plan years beginning in 2025 is $2,150 (up from $2,100 for plan years beginning in 2024).

Fourth Circuit finds exclusion of "gender-affirming" care violates ACA Section 1557. The Fourth Circuit has affirmed lower court rulings that the exclusion of coverage for "gender-affirming" care for treatment of gender dysphoria by state health plans in West Virginia and North Carolina discriminated on the basis of sex in violation of the nondiscrimination protections of ACA Section 1557, Title VII, and other federal laws. The appeals court rejected a challenge to the trial court's reliance on the Supreme Court's *Bostock* ruling in the context of a Section 1557 nondiscrimination claim. While *Bostock* held that employers violate Title VII when they discharge employees merely for being gay or transgender, Title VII addresses employment discrimination and is not determinative as to Section 1557 discrimination. The court concluded, however, that based on Fourth Circuit precedent, courts may use case law interpreting Title VII for guidance when interpreting sex discrimination under Title IX—the violation of which is a basis for a finding of discrimination under Section 1557. While Section 1557's application to group health plans remains in flux in the courts, final regulations implementing Section 1557 were issued last month (see last month's compliance update). Consistent with developing case law, the new 2024 regulations provide that "discrimination on the basis of sex" specifically includes discrimination based on sexual orientation, gender identity, sex characteristics, pregnancy, and sex stereotypes. Although covered entities are not required to provide coverage for particular health services, such as surgical treatment for gender dysphoria, the regulations prohibit the exclusion of categories of services in a discriminatory manner. As this (and other) cases demonstrate, coverage exclusions for "gender-affirming" care and surgery are being closely examined by the courts. It is likely the Supreme Court will need to weigh in on this issue at some point. In the meantime, employers and group health plans that want to exclude "gender-affirming" coverage should consult with legal counsel.

Eleventh Circuit finds exclusion of "gender-affirming" surgery violates Title VII. The Eleventh Circuit has upheld a lower court ruling that an employer-sponsored self-insured health plan violated Title VII of the Civil Rights Act because the plan excluded coverage for "gender-affirming" surgery. The lawsuit was brought by a transgender employee who had been denied coverage for surgery recommended by her physician to treat gender dysphoria. The court cited the Supreme Court's *Bostock* decision for its holding that discrimination based on transgender status necessarily entails discrimination based on sex. Applying that reasoning, the court concluded that because transgender individuals are the only plan participants who qualify for "gender-affirming" surgery, the exclusion of such surgery unlawfully discriminates against transgender participants based on their sex. This case again shows (as discussed above regarding the similar Fourth Circuit case) that coverage exclusions for "gender-affirming" care and surgery are being closely examined by the courts, and plan sponsors should continue to monitor developments and be cautious of plan provisions that could invite costly legal challenges.

Updated gag clause attestation instructions. The DOL/HHS/IRS updated the Gag Clause Prohibition Compliance Attestation (GCPCA) submission instructions and user manual (available at the CMS GCPCA website). An appendix in the submission instructions lists the changes made since 2023. As a reminder, group health plans and insurers are prohibited from entering into agreements with providers, provider networks, or entities offering provider network access that contain any contractual term directly or indirectly restricting the plan or insurer from disclosing specified data and information, such as cost or quality of care data (a "gag clause"). Plans and insurers are required to annually attest to their compliance by submitting the GCPCA by December 31 each year. For fully-insured plans, if the insurance carrier submits the attestation on behalf of the group health plan, the requirement is considered met. Self-insured plans can enter into a written agreement to have their TPA submit the

attestation on their behalf. However, a self-insured plan sponsor remains liable for any compliance failure.