Compliance Monthly Update: September 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.

2025 ACA affordability percentage increases to 9.02%. On September 6, the IRS announced that the ACA affordability percentage for plan years beginning in 2025 will be increasing to 9.02% (from 8.39% for 2024). As a reminder, under the ACA employer mandate, applicable large employers (ALEs) must offer affordable health coverage to full-time employees and dependents or face potential penalties. The annually adjusted affordability percentage is used to determine the threshold, at or below which the cost of coverage will be considered affordable. Generally, coverage offered to a full-time employee will be considered affordable if the employee's contribution for self-only coverage does not exceed the applicable percentage of the employee's household income for the taxable year. Because employers typically are unaware of what an employee's actual household income is, the rules provide three affordability safe harbors: (1) employee's Form W-2 wages; (2) employee's rate of pay; and (3) the federal poverty line. Employers should review the required employee contribution for 2025 coverage if they plan to meet the ACA's affordability limit under the applicable safe harbor.

IRS letter suggests employees have choice between different pre-tax health, retirement, and education benefits. A new IRS private letter ruling has allowed one plan sponsor to implement a flexible benefit design where employees can allocate employer contributions across a range of health, retirement, and education vehicles—including 401(k) plans, retiree HRAs, HSAs, and educational assistance programs. But employees cannot receive the employer contribution as cash or another taxable benefit. This private letter ruling is specific to the employer who requested it and cannot be broadly applied to other employers. However, the ruling does provide insight into the IRS's thinking and indicates a potential openness on the part of the IRS to this type of creative plan design. Note that this type of flexible plan design could potentially have an adverse impact on nondiscrimination testing for the various programs—because allowing choice in where employer contributions can be allocated will lead to non-uniform employer contributions to the applicable 401(k), HSA, retiree HRA, and/or educational assistance program.

Reminder about new fixed-indemnity plan notice. Earlier this year, we discussed a final rule which included a new notice requirement for plan sponsors who offer hospital indemnity and other fixed-indemnity plans that are designed to be excepted benefits (here we will refer to these plans collectively as fixed-indemnity plans). This new notice requirement takes effect for plan years beginning on or after January 1, 2025, and is designed to help consumers distinguish voluntary fixed-indemnity excepted-benefit coverage, which lack the consumer protections of federal laws like the ACA and HIPAA, from comprehensive medical coverage that is subject to those laws. For group fixed-indemnity plans, plans and insurers must prominently display the notice on the first page (either paper or electronic) of any marketing, application, and enrollment/reenrollment materials in at least 14-point font. However, when enrollment materials are bundled and describe multiple benefits (e.g., in a benefit guide), the agencies have acknowledged it will often be clearer if the notice appears in the guide immediately before the information on the fixed-indemnity plan(s) rather than the first page of the bundled material where it may not be obvious to which plan the notice applies. In the case of electronic materials, like an online

enrollment system, it should be sufficient if the notice appears on the screen immediately before, or the same screen as, where the employee actually enrolls in the fixed-indemnity plan.

DOL confirms its cybersecurity guidance applies to all employee benefit plans. On September 6, the DOL issued Compliance Assistance Release No. 2024-01 to confirm that cybersecurity guidance issued by the DOL in April 2021 generally applies to all employee benefit plans, including health and welfare plans. The update explains that, since the issuance of the initial guidance, health and welfare plan service providers have indicated to plan fiduciaries and DOL investigators that it applies only to retirement plans. So, the DOL has now expressly stated that the guidance applies to all ERISA plans, including health and welfare plans and all types of retirement plans. The guidance materials listed below have been updated to include references to health and welfare plans:

- Tips for Hiring a Service Provider. Helps plan sponsors and fiduciaries prudently select a service provider with strong cybersecurity practices and monitor their activities, as ERISA requires.
- Cybersecurity Program Best Practices. Assists plan fiduciaries and record-keepers in their responsibilities to manage cybersecurity risks. This document reinforces that health and welfare plans (along with retirement plans) can be tempting targets for cybercriminals because they handle participant personally identifiable data. The document also provides links to health care-related cybersecurity resources from HHS.
- Online Security Tips. Offers plan participants and beneficiaries, who check their retirement accounts or other employee benefit plan information online, basic rules to reduce the risk of fraud and loss.

Final mental health parity rules expand group health plan compliance requirements. On September 9, the DOL, HHS, and IRS released final rules (and an associated fact sheet) under the Mental Health Parity and Addiction Equity Act (MHPAEA), focusing on nonquantitative treatment limitations (NQTLs) and the written comparative analysis requirement that was previously established under the CAA, 2021. The final rules amend existing MHPAEA regulations to incorporate new and revised definitions of key terms and to specify the steps that plans (or insurers) must take to comply with MHPAEA. They also include provisions codifying minimum standards for NQTL comparative analyses and reflect the sunset of the non-federal governmental plan opt-out election. Legal challenges to portions of these final rules are expected, especially in light of the *Loper Bright* Supreme Court decision earlier this year holding that regulatory agencies are no longer given the same type of deference to interpret statutes when they issue regulations. Here are the highlights most important to group health plan sponsors:

- Applicability date. The final rules generally apply to group health plans for plan years beginning on or after January 1, 2025. However, several provisions—including those implementing the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, required use of outcomes data, and certain related comparative analysis requirements—will not apply until plan years beginning on or after January 1, 2026. Until these effective dates, plans still must continue to comply with existing requirements, including the CAA, 2021 amendments to MHPAEA that generally requires the written NQTL comparative analysis.
- Meaningful benefit requirement. Plans that provide any benefits for a mental health (MH) condition or substance use disorder (SUD) must provide "meaningful benefits" for that condition or disorder in every benefit classification in which meaningful medical/surgical benefits are provided. Meaningful benefits require coverage of a core treatment for the condition or disorder in each classification in which the plan covers a core treatment for one or more medical conditions or surgical procedures. For example, if a plan generally covers autism but excludes

coverage for applied behavior analysis (ABA) for autism spectrum disorder, it would almost certainly violate the meaningful benefits requirement.

- Requirements for NQTLs. Plans may not impose NQTLs with respect to MH/SUD benefits in any classification that are more restrictive, as written or in operation, than the predominant NQTL that applies to substantially all medical/surgical benefits in the same classification. Acknowledging concerns that NQTLs are inherently nonquantifiable, the agencies declined to finalize a proposed mathematical test for defining "substantially all" and "predominant." In implementing an NQTL, the plan must satisfy two sets of requirements:
    - *Design and application requirements*. The plan must examine the processes, strategies, evidentiary standards, and other factors used in designing and applying an NQTL to MH/SUD benefits in the classification to ensure they are comparable to, and applied no more stringently than, those used in designing and applying the limitation with respect to medical/surgical benefits in the same classification. Also, plans may not use discriminatory factors and evidentiary standards in designing an NQTL to be imposed on MH/SUD benefits. Generally recognized independent professional medical or clinical standards are considered nonbiased and objective, as are carefully circumscribed measures reasonably designed to detect or prevent and prove fraud and abuse and minimize the negative impact on access to appropriate MH/SUD benefits.
    - *Relevant data evaluation requirements*. Plans must (1) collect and evaluate relevant data, which may vary based on the facts and circumstances, but includes data on network composition; (2) assess the data and determine whether the data suggest an NQTL contributes to material differences in relevant outcomes related to access to MH/SUD benefits compared with medical/surgical benefits; and (3) if material differences in relevant outcomes related to access exist, take reasonable action to address the material differences to ensure operational compliance. When collecting and evaluating data to assess the NQTLs' impact on relevant outcomes, this may entail reviewing in-network and out-of-network utilization rates, provider reimbursement rates, and the number of providers within a certain geography or providers accepting new patients. If the number of providers in the network is too low, reasonable steps should be taken to correct or expand the network.
- Comparative analysis requirement. Plans must perform and document NQTL comparative analyses and submit them to a requesting agency (e.g., the DOL) within ten business days of the request. The analysis must:
    - (1) Describe the NQTL, including identification of benefits subject to the NQTL.
    - (2) Identify and define the factors and evidentiary standards used to design or apply the NQTL.
    - (3) Describe how factors are used in the design or application of the NQTL.
    - (4) Evaluate whether processes, strategies, evidentiary standards, or other factors are comparable to, and applied no more stringently than, those with respect to medical/surgical benefits, as written.
    - (5) Evaluate whether processes, strategies, evidentiary standards, or other factors are comparable to, and applied no more stringently than, those with respect to medical/surgical benefits, as applied in operation—including the required data, evaluation of that data, explanation of any material differences in access, and description of reasonable actions taken to address such differences.
    - (6) Address findings and conclusions regarding comparability and relative stringency.

  Plans must also prepare and make available to the agencies, upon request, a written list of all NQTLs imposed under the plan. An exhaustive list of NQTLs was not provided by the regulatory

agencies (as was requested by commenters)—so, plans should use a best faith effort to analyze any NQTL that limits the scope or duration of treatment. The agencies intend to provide additional examples of NQTLs in future updates to the MHPAEA Self-Compliance Tool.

- Requirement to provide comparative analysis to individuals. For plans subject to ERISA, they must provide a copy of their NQTL comparative analyses to any participant, beneficiary, or enrollee within 30 days upon the individual's request.
- Fiduciary certification. For plans subject to ERISA, the comparative analysis must include a certification that at least one plan fiduciary has engaged in a prudent process to select qualified service providers to perform and document a comparative analysis in connection with the imposition of any NQTLs applied to MH/SUD benefits under the plan, and that the fiduciaries have satisfied their duty to monitor those service providers.

Eleventh Circuit overturns its prior ruling that an exclusion of "gender-affirming" surgery violated Title VII. The Court of Appeals for the Eleventh Circuit has vacated its prior holding that an employer sponsoring a self-insured health plan violated Title VII of the Civil Rights Act because the plan excluded coverage for gender-affirming surgery. We discussed the prior ruling in our May 2024 compliance update about a transgender employee who sued because they had been denied coverage for surgery recommended by their physician to treat gender dysphoria. In that prior ruling, a three-judge panel of the Eleventh Circuit 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. After that ruling, the employer petitioned for a rehearing by the full Eleventh Circuit and the court agreed to the rehearing and vacated the panel's prior opinion. This case shows (again) that coverage exclusions for "gender-affirming" care and surgery are being closely examined by the courts under nondiscrimination laws under Title VII and ACA Section 1557. Plan sponsors should continue to monitor developments and be cautious of plan provisions that could invite costly legal challenges.