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HEALTH PLAN DEVELOPMENTS

New Safe Harbor for Transparency In Coverage Rule's In-Network Machine-Readable File

The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (the Departments) recently announced a limited enforcement safe harbor for the in-network medical machine-readable file required under the Transparency in Coverage Final Rule (the Rule).

Under the Rule, non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets must disclose, on a public website, information regarding in-network provider rates in a machine-readable file. The Rule also requires plans and issuers to post machine-readable files for (1) out-of-network allowed amounts and billed charges; and (2) negotiated rates and historical net prices for prescription drugs. The Departments are not enforcing the in-network and out-of-network machine-readable file requirements until July 1, 2022, or the first month of the plan or policy year in 2022 if later. The file requirement for prescription drugs is pended until future rulemaking.

Pursuant to the Rule, machine-readable files must list rates in dollar amounts. However, under the new safe harbor plans and issuers that use "percentage-of-billed-charges" contracts with in-network providers for particular services can instead disclose the reimbursement percentage. The Departments determined that the safe harbor was necessary because under these types of contracts, the dollar amount cannot be known until the provider bills for the service, and the billed charge can vary. The Departments also extended a safe harbor to other in-network services for which providers are reimbursed under arrangements not supported by the Department's machine-readable file schema, or that need additional context to be understood. In those cases, plans and issuers may describe the arrangement in an open text field.

Agencies Publish Guidance on Federal IDR Process Under No Surprises Act

The Departments published guidance to clarify the independent dispute resolution (IDR) process for group health plans, health insurers and out-of-network providers under the No Surprises Act. The IDR process comes into play

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when the out-of-network providers do not agree with the amount the plan or issuer paid for services that the provider cannot balance bill to the patient under the No Surprises Act. The guidance is not binding, but provides information on the entire lifecycle of a disputed claim, from the steps that must precede IDR to its conclusion. Covered topics include:

- Plan or Issuer's Initial Payment or Claim Denial
- Open Negotiations
- Initiating the Federal IDR Process
- Selection of the Certified IDR Entity
- Submission of Offers and IDR Entity Fees
- Factors and Information Certified IDR Entities Must Consider
- Certified IDR Entity's Offer Selection and Written Decision
- Effect of the Determination
- Extensions of Time Periods
- Fees

The guidance also includes a chart summarizing the steps in the entire process and providing links to the standard notices required at different stages.

The Departments also published similar guidance for certified IDR entities. The guidance generally covers the same topics, but also discusses:

- Conflicts of Interest for Certified IDR Entities
- Determining Whether the Federal IDR Process Applies to the Dispute
- Recordkeeping and Reporting Requirements
- Confidentiality Requirements
- Revocation of Certification

IRS Announces 2023 Limits for HSAs, HDHPs and Excepted Benefit HRAs

The IRS announced adjusted limits for 2023 for health savings accounts (HSAs),

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high deductible health plans (HDHPs) and excepted benefit health reimbursement arrangements (EBHRAs) in Revenue Procedure 2022-24.

Eligible individuals can contribute up to the following amounts to their HSAs in 2023:

- $3,850 if they have self-only HDHP coverage;
- $7,750 if they have family HDHP coverage.

The 2023 HSA contribution limits reflect increases of $200 and $450, respectively, over the 2022 limits.

Health plans will qualify as HDHPs for 2023 if they meet the following standards:

- An annual minimum deductible of $1,500 for self-only coverage and $3,000 for family coverage (increases of $100 and $200 from 2022); and
- An annual out-of-pocket maximum of no more than $7,500 for self-only coverage and $15,000 for family coverage (increases of $450 and $900 from 2022).

Employers that sponsor EBHRAs can make up to $1,950 newly available to participants for the plan year beginning in 2023. This is an increase from the prior contribution limit of $1,800 per plan year.

Aspirin No Longer Recommended As ACA Preventive Care for Cardiovascular Disease

The U.S. Preventive Services Task Force (USPSTF) recently downgraded its recommendation for low-dose aspirin to prevent cardiovascular disease (CVD). Under the Affordable Care Act, non-grandfathered group health plans and health insurers will no longer need to cover aspirin as preventive care for CVD as of the first day of the next plan year beginning on or after April 26, 2022. However, plans and insurers must continue to cover aspirin as preventive care based on the prior USPSTF Grade B recommendation until that time.

The prior Grade B recommendation generally applied to those aged 50 to 59 who have a 10 percent or greater 10-year CVD risk. Now, the USPSTF gives a Grade C recommendation for low-dose aspirin to prevent CVD in those aged 40 to 59 who have a 10 percent or greater 10-year CVD risk. This change in the recommendation for CVD does not affect the separate recommendation for the

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use of low-dose aspirin to prevent preeclampsia in those with high-risk pregnancies.

IRS Proposes to Expand ACA Premium Tax Credit Eligibility Based on Affordability of Family Coverage, But No Change in Affordability Requirements for Employers

Under the ACA, people without access to "affordable" health coverage under their employer's health plan may qualify for a premium tax credit to help them pay for a policy on the ACA's health insurance Marketplaces. However, "affordable" is determined based on the employee's cost for the lowest-cost, self-only coverage option that provides minimum value. The family members of these employees who are offered "affordable" self-only coverage, but may not be offered truly affordable family coverage, can be left in a difficult position because they are not eligible for premium tax credits. This has been referred to as the "family glitch."

On April 5, 2022, the Treasury Department and the IRS proposed regulations that would eliminate the family glitch. If the rule is finalized, family members of employees who are offered affordable self-only coverage, but unaffordable family coverage, may qualify for premium tax credits. In particular, the proposed rule would make it such that, just for purposes of qualifying for the premium tax credit, the entire family's coverage would be considered affordable only if the employee's cost for family coverage does not exceed 9.5 percent (as adjusted) of household income.

The proposed rule would not change the ACA employer mandate, which determines whether an applicable large employer (with 50 or more full-time and full-time equivalent employees) provides affordable coverage based on the lowest-cost, *self-only* coverage option available to the employee. Employer-sponsored health coverage is considered "affordable" under the ACA for 2022 if an employee's contribution is no more than 9.61 percent of his or her income, which is usually determined under a safe harbor.

HHS Requests Information on Rules Encouraging HIPAA Entities to Adopt Cybersecurity Practices and Requiring Distribution of Civil Monetary Penalties and Settlements to Harmed Individuals

HHS's Office for Civil Rights (OCR) issued a Request for Information (RFI) seeking input on HIPAA covered entities' and business associates' voluntary implementation of certain cybersecurity practices. In 2021, Congress passed legislation that requires HHS, when enforcing HIPAA, to consider whether a HIPAA covered entity or business associate had implemented certain "recognized

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security practices." If a covered entity or business associate can show that, for at least the prior 12 months, it had fully implemented such practices, HHS has leeway to impose lower fines, shorten audits and allow different remedies for security breaches. The RFI reveals that HHS will require the covered entity or business associate to show that it was actively and consistently using its recognized security practices. The RFI also asks covered entities and business associates how they understand and are implementing "recognized security practices," how they would show that recognized security practices are in place and other implementation issues they are considering or would like OCR to clarify. In addition, the RFI asks for input on a HITECH Act requirement for HHS to establish a method to distribute a percentage of a civil monetary penalty or monetary settlement to individuals who are harmed by HIPAA noncompliance. Specifically, OCR is seeking comments on the types of harms that should be considered and the potential methodologies for sharing and distributing the amounts. Comments on the RFI are due by June 6, 2022.

Multiemployer Plan Trustees Abused Discretion by Relying on Medical Reviewer's Opinion Based On Incomplete Medical Records

The U.S. Court of Appeals for the Fourth Circuit recently determined that a multiemployer health plan's board of trustees abused their discretion by denying an appeal based on medical necessity after the plan failed to provide complete medical records to its independent medical reviewer. The court did not think the plan and trustees acted in bad faith, but regardless found that participants are owed a "deliberate, principled reasoning process" – and that the process for this participant fell short. The court agreed with and even encouraged plan trustees to rely on independent medical reviews in making benefit decisions. However, in order for the trustees to make a reasoned determination based on the independent medical reviewer's opinion, the medical reviewer needs complete information.

The court also took issue with the trustees' interpretation of medical necessity, under which they considered the participant to have needed to pursue more conservative treatment before her surgery. Aside from the participant in fact having done so, the court found no requirement for the participant to pursue more conservative treatment in the first instance in the plan.

The case is *Garner v. Central States, Southeast and Southwest Areas Health and Welfare Fund Active Plan*, case number 21-1602, in the Fourth Circuit. The court issued its published decision on April 20, 2022.

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RETIREMENT PLAN DEVELOPMENTS

IRS Issues Updated Mortality Improvement Rates and Static Mortality Tables for Defined Benefit Pension Plans for 2023

In Notice 2022-22, the IRS provided updated mortality improvement rates and static mortality tables to be used for defined benefit pension plans under Code section 430(h)(3)(A) and ERISA section 303(h)(3)(A). These updated mortality improvement rates and static mortality tables apply for plans to determine present value and make any other computation under section 430 for valuation dates in 2023. The mortality improvement rates are those included in the Mortality Improvement Scale MP-2021 Report issued by the Retirement Plans Experience Committee of the Society of Actuaries. The notice also includes a modified unisex version of the mortality tables for determining minimum present value under Code section 417(e)(3) and ERISA section 205(g)(3) for distributions with annuity starting dates that occur during stability periods beginning in the 2023 calendar year.

IRS Proposes Rules on Mortality Tables for Determining Present Value under Defined Benefit Pension Plans

The IRS and the Treasury Department have proposed a rule with the methodology they would use to update the generally applicable mortality tables for defined benefit pension plans to determine present value and make computations under Code section 430. Multiemployer plans and a cooperative and small-employer charity (CSEC) plans would also use these updated tables to determine current liability, and a modified version of the tables would apply to determine the amount of a single-sum or accelerated form of distribution. The proposed regulations keep the 2017 regulations' separate determination of base mortality tables and the projection of mortality improvement. If finalized, the rule would apply for plan years beginning in 2023.

The deadline for those who are interested to provide comments is June 9, 2022. A public hearing on the proposed regulations is scheduled for June 28, 2022, at 10:00 a.m. (EST).

California District Court Declines to Consider IRS Regs in Deciding Anti-Cutback Case

The U.S. District Court for the Central District of California issued an unusual decision in March related to the "anti-cutback" rule under ERISA and the Code. In it, the court refused to consider the Treasury regulations that plan sponsors have relied on for decades to distribute a benefit without the consent of the participant

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at the later of age 62 or normal retirement age.

The plaintiff in the case is a participant in Willis Towers Watson's pension plan for U.S. employees. Until 2017, the plan allowed participants to defer receipt of their pension benefits until age 70. However, in July 2017, the plan was amended to require terminated vested participants to begin receiving their benefit by age 62. The plaintiff filed a claim to defer his benefit until age 70, and sued when his request was denied, arguing that the amendment was an illegal cutback of his vested and accrued benefits.

The court agreed that the right to defer benefits until age 70 was an optional form of benefit under the plan that was protected by the anti-cutback rule. It also found that because the amendment eliminated the plaintiff's deferral right without his consent, it was an involuntary distribution. Therefore, the court needed to determine whether it was an involuntary distribution that was permitted under Code sections 411(a)(11) and 417(e).

Coming as a surprise to many, however, the district court decided that it did not need to consider the regulations under those Code sections to properly interpret them, and instead could make its decision based on the statutory language alone. The court based its reasoning on a quote from the U.S. Court of Appeals for the Ninth Circuit, in which it stated that its “inquiry begins with the statutory text, and ends there as well if the text is unambiguous.” *In re Stevens*, 15 F.4th 1214, 1217 (9th Cir. 2021) (quoting *BedRoc Ltd., LLC v. United States*, 541 U.S. 176, 183 (2004)). The district court found sections 411(a)(11) and 417(e) unambiguous, and to permit involuntary distributions only if the benefit does not exceed $5,000 in value.

Unfortunately, the defendants had based their action in adopting the amendment, and their whole argument for the case, on the regulations under Code sections 411(a)(11) and 417(e). Those regulations allow a plan to distribute a benefit without a participant's consent once they are age 62 or normal retirement age, if later, and plan sponsors have relied on them to do so for decades without violating the anti-cutback rule. This decision now calls that reliance into question, at least in California. Plan sponsors can only hope that the plan appeals and this decision is overturned, or at a minimum that it remains an outlier. The case is *Cooper v. Willis Towers Watson Pension Plan for U.S. Emps*, 2022 WL 807418 (C.D. Cal. Mar. 3, 2022).

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UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Health Plan Deadlines

Machine-Readable Files for In- and Out-of-Network Medical Payment Rates – Enforced as of July 1, 2022, if the first day of the plan year is on or before July 1, or as of the first day of the plan year beginning thereafter.

- The DOL, HHS and Treasury will begin enforcing the Transparency in Coverage final rule's requirement for non-grandfathered group health plans to publicly disclose on a website two machine-readable files with information on the plan's payment rates for medical benefits. One file will disclose in-network provider rates and the other will disclose historic non-network allowed amounts and billed charges.

These materials provide general information which does not constitute legal or tax advice and should not be relied upon as such. Particular facts or future developments in the law may affect the topic(s) addressed within these materials. Always consult with a lawyer about your particular circumstances before acting on any information presented in these materials because it may not be applicable to you or your situation. Providing these materials to you does not create an attorney/client relationship. You should not provide confidential information to us until Reinhart agrees to represent you.

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