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BENEFIT SOLUTIONS

BENEFITS LEADER

Your Guide to Health & Welfare Compliance

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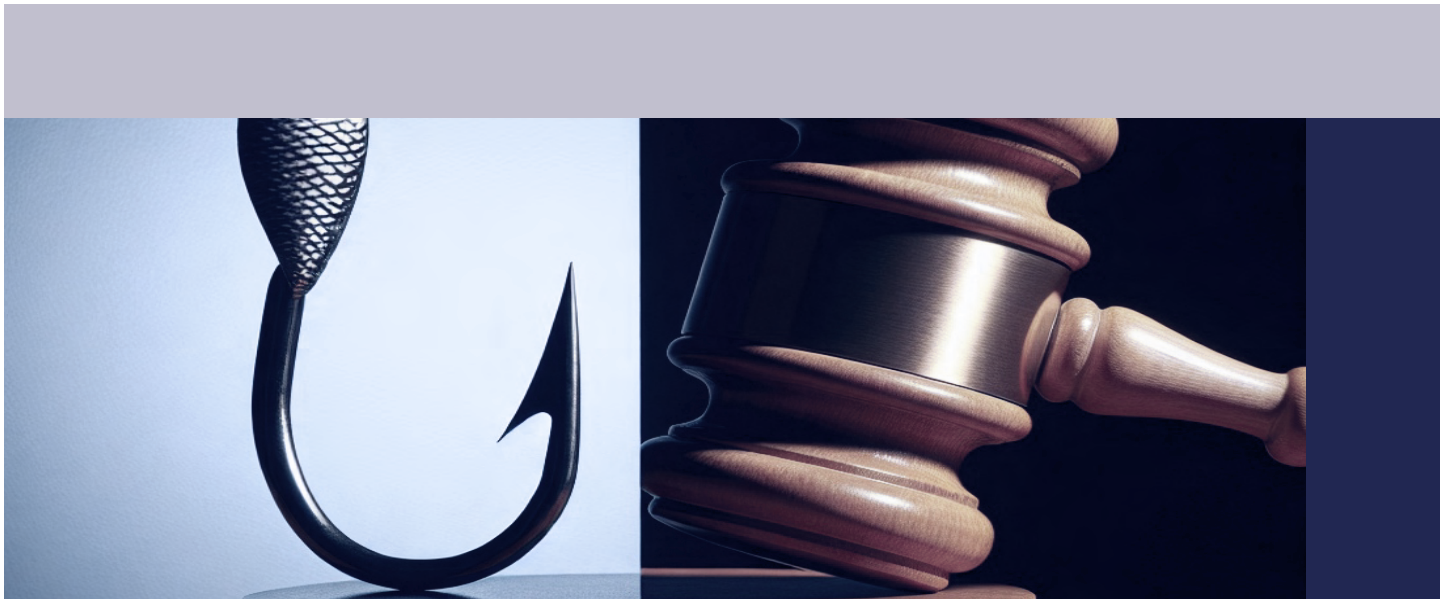
IN THIS ISSUE

DING, DONG, THE CHEVRON DEFERENCE, IS DEAD
WHAT THIS MEANS FOR GROUP HEALTH PLANS

Michelle Barki, RN, JD, Senior Legal Counsel

You might not expect a group of New England herring fishermen, who opposed a rule mandated by the National Machine Fisheries Services requiring them to both allow and pay for federal monitors on their boats, to change modern agency law. But they did. The Supreme Court's recent decision in *Loper Bright Enterprises v. Raimondo* No: 21-5166 (June 28, 2024) has effectively ended Chevron Deference, impacting agencies like the Department of Labor (DOL) and the Department of Health and Human Services (HHS).

So, what was the Chevron Deference that was killed? In 1984, the United States Supreme Court in *Chevron USA v. National Resource Defense Council Inc*, 467 U.S. 837 gave deference to agencies to interpret ambiguous statutes passed by Congress and to interpret congressional intent. In short, not only do agencies write the rules based on statutes, but they were also given the authority to determine congressional intent if their interpretation was reasonable. Constitutionally, the authority to interpret statutes was to be left to the courts, but the courts, relying on the agencies' expertise, passed that responsibility on. The lower courts lost authority, and the agencies became powerful.



Think of where we were in the benefits arena when Chevron was passed. Sure, we had the Workers Compensation Act (1948), the Public Health Service Act of 1944 (PHSA), and the Employee Retirement Income Security Act of 1974 (ERISA), but things were simpler and evolving. Since Chevron, there has been an onslaught of new laws ripe for the agencies to interpret. We have had COBRA (1986), ADA (1990), FMLA (1993), HIPAA (1996), Mental Health Parity Act (1996), ACA (2010) and the CAA (2021). That is a lot of power given to the DOL and the HHS, and we have seen the results of multiple rules imposed. Benefits administration has become a maze of rules and regulations to navigate.

So, what changes now that the Courts have taken action? It remains to be seen. However, the Department of Health and Human Services has already had its rules on gender-affirming care placed on hold via injunctions since the Loper Bright decision, which shows the courts' willingness to resume control. See our article entitled *Gender-Affirming Care Under ACA Section 1557*

Stay tuned as the next few years will see an increase in litigation as agencies write rules and legal challenges are mounted questioning congressional intent. This decision is anticipated to have a major impact on reining in the agency's control.

GENDER-AFFIRMING CARE UNDER ACA SECTION 1557

Michelle Barki, RN, JD, Senior Legal Counsel

Gender-affirming care for minors and adults has become a hot topic in the benefits world as employers throughout the land may or may not want to cover the cost of the care, especially when it comes to minors. The question becomes, what flexibility do employers have, especially when it comes to minors, and does it matter if the group is fully insured or self-funded? Let's first address the issue from the perspective of the recent rules promulgated by the Department of Health and Human Services on May 6, 2024.

MAY 6, 2024: NEW HHS RULE UNDER SECTION 1557

The Department of Health and Human Services issued a strong policy statement in October 2022 supporting transgender care for minors. The Department stated:

"The Department of Health & Human Services (HHS) stands with transgender and gender nonconforming youth and their families—and the significant majority of expert medical associations—in unequivocally stating that gender affirming care for minors, when medically appropriate and necessary, improves their physical and mental health. Attempts to restrict, challenge, or falsely characterize this potentially lifesaving care as abuse is dangerous. Such attempts block parents from making critical health care decisions for their children, create a chilling effect on health care providers who are necessary to provide care for these youth, and ultimately negatively impact the health and well-being of transgender and gender nonconforming youth.

As a law enforcement agency, OCR is investigating and, where appropriate, enforcing Section 1557 of the Affordable Care Act cases involving discrimination on the basis of sexual orientation and gender identity in accordance with all applicable law."

In May 2024, the Department of Health and Human Services (HHS) issued sweeping new rules regarding Section 1557 of the Affordable Care Act following an executive order by President Biden. The order charged HHS to work with states to promote access to gender-affirming care for minors. These new rules also fulfilled their policy statement written in October 2022.

Section 1557 was the vehicle used to mandate gender-affirming care for adults and minors. Section 1557 is the nondiscrimination provision of the ACA that prohibits discrimination based on race, color, national origin, sex, age, or disability in specified health activities, including those that receive federal financing. Covered entities include "health programs or activities that receive direct or indirect financial assistance from HHS health program and activities." This includes State Medicaid, Medicare Part B, many health insurance plans, and most hospitals and providers

While group health plans are not covered entities under Section 1557 (except in very rare circumstances), they are affected. Fully insured carriers with plans on the Marketplace or who administer Medicare Advantage Plans are covered entities and must include gender-affirming care in their insurance policies directed to group health plans on the first day of the plan year commencing in 2025. In addition, self-funded plans can very well be affected as well, depending on the TPA. The Department of Health and Human

Article continues on next page.

Services has made it clear that TPAs associated with carriers who have benefits on the Marketplace or Medicare Advantage Plans are subject to Section 1557, and they could be held liable if coverage is not offered in accordance with Section 1557, although the TPA may be able to present a defense depending on the facts and circumstance. So, the message from HHS was that they expected coverage to be offered for gender-affirming care to most employees and family members covered under employer-sponsored health plans, adults and minors alike. The effective date is the first day of the plan year in 2025. However, if the employer qualifies for a religious exemption based on a deeply held religious belief, this would be constitutionally allowed if proven.

WHAT DO THE STATES SAY?

While the Department of Health and Human Services mandated coverage for gender- affirming care commencing in 2025 for most group health plans, some states have passed laws prohibiting care, especially when it comes to minors. Currently, 26 States have banned, entirely or in part, puberty blockers and surgical care for minors. These states include: Arizona, Alabama, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisianna, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wyoming.

It's obvious that the country is widely divided when it comes to gender-affirming care for minors. It is also true that one of two choices remains, and health plans are in a quandary: do they violate state law or violate federal law? This is a no-win situation.

THE COURTS HAVE STEPPED IN

Three lawsuits have been filed by various State Attorney Generals opposing the HHS mandate for gender-affirming care, especially for minors. These cases are the first indications that *Loper Bright Enterprises et al. v. Raimondo*, Secretary of Commerce, 219 L. Ed. 2d 832 is already taking effect. In each of the three cases, the courts did not allow the Chevron Deference to the HHS.

In *Florida v. Department of Health and Human Services*, 8:224-cv-1080-WFJ-TGW, the court issued a stay that affected enforcement of Section 1557 in Florida only. The Court recognized the conflict violated Florida Law. The court also stated that an injunction was proper based on the fact that the public interest is served because the HHS "rule is ever-changing and unstable, buffeted by the prevailing political winds. The new Rule is the fourth version in the last eight years, which each version the opposite of the other. The repeated reversing of field by HHS presents large compliance issues and costs for health care facilities and the states that regulate them; not to mention the stop-and-start effect on this sensitive area of health policy. This instability suggests that the public interest favors a preliminary pause to fully address on the merits this new, fourth version. And the instability shows little harm to HHS in keeping a steady hand rather than lurching change."

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- An Overview of COBRA
- Leaves of Absence, FMLA, and ADA
- ACA Compliance
- CAA Requirements

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The second case, *Texas v. Becerra, No. 6:24-cv-JDK (E.D. Tex.)*, stayed the 2024 final rule in its entirety in Texas and Montana. In part, the court concluded that "the public interest is always served when public officials act within the bounds of the law and respect the rights of the citizens they serve" *Camacho v. Tex. Workforce Comm'n*, 326 F. Supp. 2d 794, 802 (W.D. Tex. 2004) (quoting *Finlan v. City of Dallas*, 888 F. Supp. 779, 791 (N.D. Tex. 1995)). The Final Rule likely violates the law and exceeds the scope of HHS's authority. The public interest in an injunction thus outweighs HHS's interest in the freedom to implement its own policies. *See Wages & White Lion, 16 F.4th at 1143 ("[T]here is generally no public interest in the perpetuation of unlawful agency action." (quoting Texas v. Biden, 10 F.4th 538, 560 (5th Cir. 2021)).*

Finally, in the case of *Tennessee v. Becerra*, No.1:24cv161-LG-BWR (S.D. Miss) issued a nationwide injunction to the extent that discrimination includes discrimination based on gender identity. This court recognized, as did the other two above, that when Title 1X was enacted under which Section 1557 is based, the word "sex" indicated male and female. Consequently, this Court cannot accept the suggestion that Congress, with a "clear voice," adopted an ambiguous or evolving definition of "sex" when it acted to promote educational opportunities for women in 1972. In short, without explicit statutory authority and with the Chevron Doctrine dismantled, the court was unwilling to accept that the statute was meant to cover gender-affirming care.

In short, for now, there is a stay on forcing group health plans to cover gender-affirming care, especially for minors. Certainly, those who want this covered are free to do so, but there is no Federal Mandate currently under the Department of Health and Human Services' new rules to do so.

Litigation is expected to continue and potentially reach the Supreme Court based on the merits. However, one thing is for sure, Congress has not spoken with a clear voice.

BIG CHANGES AHEAD FOR MEDICARE PART D & CREDITABLE COVERAGE

Michelle Barki, RN, JD, Senior Legal Counsel

Medicare Part D benefits are expanding in 2025, bringing big changes for those on Medicare. However, these changes may pose challenges for Group Health Plans in providing Part D credible coverage. Creditable coverage is when the actuarial value of the group health plan's drug benefit exceeds or equals the actuarial value of Medicare Part D.

The Inflation Reduction Act provided that for 2024, Part D enrollees no longer have to pay the 5% of catastrophic coverage. While this did not largely impact the 2024 plan years and credible coverage, the changes to Medicare Part D in 2025 are expansive and will affect credible coverage. The major changes include a substantial reduction in the maximum out-of-pocket for Medicare Part D from $8,000 to $2,000, as well as the elimination of the "donut hole" in Medicare coverage.

While this is a welcome relief for Medicare Part D recipients, group health plans may struggle to maintain comparable coverage and could lose credible status, especially for High Deductible Health Plans (HDHPs). Although there are no mandates or penalties for employers who do not offer credible coverage, Medicare recipients who elect group health coverage in lieu of Medicare Part D may face penalties in the form of increased premiums for life when they eventually sign up for Medicare Part D.

Medicare Part D notices are due by October 15, coinciding with Medicare open enrollment. In addition, if a plan changes from offering credible coverage to offering non-credible coverage, Medicare Part D eligible employees must be notified of the change within 30 days.

The upcoming changes to Medicare Part D in 2025 present a double-edged sword. While they provide significant financial relief to Medicare recipients by lowering out-of-pocket costs and eliminating coverage gaps, they simultaneously impose new challenges on group health plans striving to offer creditable coverage. It is important that employers communicate any changes in credible coverage status to Medicare-eligible employees so they can make the most informed decisions about their healthcare options.

WRAPPING OUR MINDS AROUND NONDISCRIMINATION TESTING

Derek Ashton, CEBS, Strategic Client Relationship Consultant

It has been said that the Tax Code's nondiscrimination testing (NDT) standards may be among the most convoluted, complex, and confusing of all compliance requirements for health and welfare benefit plans. In some cases, the difficulty of this subject matter is magnified by the application of extensive IRS regulations, while in other cases, it is intensified by the IRS's complete lack of explanation or clarification.

While the statutory provisions within the Tax Code seem fairly straightforward, the level of complexity greatly increases due to a wide array of inconsistent exclusions, safe harbors, special rules, exceptions, and ambiguities, along with considerable variation in the interpretation and application of the concepts. For most employers, adding a nondiscrimination testing expert to the team just to ensure compliance in this area would be impractical and cost-prohibitive. As a result, confusion persists with regard to this very dense subject matter. In order to deepen our understanding of this fog-shrouded regulatory labyrinth, the remainder of this article will review the broad sweep of applicable rules and summarize key concepts before offering several practical approaches by which employers may avoid NDT trouble.

NOT JUST FOR RETIREMENT PLANS: NDT FOR HEALTH & WELFARE PROGRAMS

In the process of developing and clarifying its intent relating to the statutory NDT provisions within the Tax Code, Congress indicated to the Treasury Department that these rules should be addressing welfare programs, and applied very differently than the rules for 401(k) and other retirement plans—even in cases where the wording is substantially similar. As a result, an understanding of retirement plan NDT rules offers limited value for health and welfare benefit programs. The chart below outlines the wide variety of health and welfare plans to which NDT rules may apply and identifies the relevant Tax Code sections:

TAX-ADVANTAGED WELFARE BENEFIT PLAN	CODE SECTION
Self-Funded Medical, Dental, or Vision Plans, HRAs, Health FSAs	Section 105(h)
Cafeteria Plans (including Premium Only Plans)	Section 125
HSA Contributions	Pre-tax contributions made through a cafeteria plan are subject to Section 125 testing, and Employer Contributions made outside of a cafeteria plan are subject to comparability rules.
Dependent Care FSAs (DCAPs)	Section 129
Group Term Life Insurance Plans	Section 79
Adoption Assistance Programs	Section 137
Educational Assistance Plans	Section 127
VEBA Benefits	Section 505(b)

Note: Although no specific nondiscrimination rules apply directly to fully insured medical, dental, or vision plans, Section 125 NDT rules typically do apply since these plans are customarily offered through cafeteria plans.

Each of the statutory nondiscrimination provisions includes two or more parts, and each part may involve multiple component tests. Many of the component tests are quantitative in nature, requiring calculation of the total number of employees (possibly after the application of allowable exclusions), the number or percentage of employees in the rank-and-file group(s) and prohibited group(s), the number or percentage of employees participating in the plan(s), percentages or ratios of contribution amounts for applicable employee groups or eligibility classes, and other factors. Test components may also be qualitative in nature, evaluating whether the same types of benefits are offered to all employees in a specified class, whether employee classifications are reasonable and based on valid business criteria, whether waiting periods and eligibility requirements are permissible, and an analysis of other factors.

AVOIDING DISCRIMINATION

In a general sense, all of the Tax Code rules aim to ensure rank-and-file employees have access to (or, in some cases, actually receive) a "fair share" of a plan's tax benefits when compared to members of a "prohibited group" (e.g., high-earners, owners, officers). These rules focus on preventing economic disparities, not other forms of discrimination covered under other laws like HIPAA, ADEA, ADA, or EEOC.

REGULATORY STATUS OF THE MAJOR CODE SECTIONS

The most commonly conducted welfare plan NDT tests are those under Code Sections 125, 105(h), and 129. The chart below summarizes the legislative and regulatory status of these testing regimens.

Despite the asymmetric regulatory status of the various NDT rules, employers offering plans subject to these requirements are well-advised to proceed with testing on an annual basis to ensure compliance.

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STATUTE & PLAN TYPE	REGULATIONS
§125 Cafeteria Plans	• Proposed Regulations were issued in 2007 • These regulations have been considered effective as of 2009
§105(h) Self-Funded Plans	• Final Regulations were issued in 1981 • The statute was repealed in 1986 and then reinstated in 1989 • The IRS has listed this as a "no rule" area for which no Private Letter Rulings will be issued
§129 Dependent Care Assistance Plans	• Section 129 was added to the Internal Revenue Code (IRC) in 1981 • No Regulations have been issued • Regulators have not provided revenue procedures, announcements, or notices

WHEN TO CONDUCT TESTING

Due to potentially heavy tax implications, it's best to avoid addressing a failure after the plan year has ended. Thus, conducting testing during the plan year is strongly recommended, with plenty of time remaining to make needed adjustments. Medcom generally recommends completing testing near or shortly after the midpoint of the plan year.

STRATEGIES FOR REDUCING RISK

1. Treat all employees exactly the same with regard to all health and welfare plans.
2. Use employer "seed" contributions to encourage participation by lower-paid, rank-and-file employees.
3. Place a limit or cap on the benefits or contributions available to members of the prohibited group(s).
4. Design the plan to discriminate in favor of lower-paid employees.
5. In cases where the plan brings concerns or "red flags," test early and often so that any issues may be identified and addressed.

In addition, two rarely used approaches would practically guarantee a passing result in most cases:

1. Disallow participation by members of the prohibited groups.
2. Provide all employees with benefits at no cost.

Although the subject matter is dauntingly complex, employers can successfully navigate the deep waters of NDT with the support of experienced consultants and seasoned compliance professionals. In the event a plan fails testing, immediate solutions are available, strategies for future success can be implemented, and a passing result for the current plan year may still be achieved once corrective action has been confirmed. Whether the testing leads to necessary corrective action or merely confirms compliance, employers will rest easy knowing a passing report card is safely tucked away in their files.

HIPAA & NEW PROTECTIONS FOR REPRODUCTIVE HEALTH

Michelle Barki, RN, JD, Senior Legal Counsel

The Department of Health and Human Services (HHS) has just published new rules under HIPAA, which will go into effect in December 2024. The new regulations focus on privacy protections for reproductive health. Finalized on April 22, 2024, these new rules aim to better protect patient confidentiality and prevent medical records "used against people for providing or obtaining lawful reproductive health care." In addition, there is the presumption that reproductive health care is legal unless there is actual knowledge that it was provided illegally, such as by an unlicensed practitioner.

According to the HHS, the final rule probits the use or disclosure of PHI for:

1. "Conducting a criminal, civil, or administrative investigation into or impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, where such health care is lawful under the circumstances in which it is provided.
2. The identification of any person for the purpose of conducting such investigation or imposing such liability."

Under the final rules, the prohibition applies when:

- The services are legally sought and obtained even if interstate travel is involved
- Services are constitutionally obtained, such as receiving contraceptives, which must upheld by all states

ACTIONS REQUIRED FOR SELF-FUNDED HEALTH PLANS

- Updating the Notice of Privacy Practices
- Revising Policies and Procedures to reflect new rules
- Conducting training to ensure compliance with the new regulations
- Submitting attestations will be required when requesting information that the request is not for prohibited purposes (HHS will provide a model attestation form before the new rules go into effect)

For more information, please refer to the HHS website.

UPCOMING DEADLINES

SEPTEMBER 30

SAR DUE FOR CALENDAR YEAR PLANS & MLR REBATE REPORTING DUE

- A Summary Annual Report (SAR) summarizes the Form 5500 and is required for any plan subject to Form 5500 filing, except for self-insured plans without any segregation of assets in a trust or otherwise (unfunded)
- Carriers are required to report prior year MLR data to HHS by July 31 but If the MLRs are not met, premium rebates must be provided to employers by the end of September

OCTOBER 14

DISTRIBUTE MEDICARE PART D NOTICES

OCTOBER 15

5500 FILING DUE DATE (WITH EXTENSION) FOR CALENDAR YEAR PLANS

Employers must file 5500s for plans with at least 100 participants (i.e., employees) at the start of the plan year. In addition, employers with plans that have fewer than 100 participants must file a 5500 if the plan is "funded" (i.e., the plan's assets are segregated from the general assets of the plan sponsor through a trust).

DECEMBER 29

EMPLOYER TO DISTRIBUTE PORTION OF MLR REBATE THAT IS CONSIDERED PLAN ASSETS

Employers sponsoring fully insured group health plans must distribute the portion of an MLR Rebate that is considered plan assets within 90 days of receipt (i.e., for rebates received September 30, by December 29). Otherwise, the employer may be subject to the general ERISA trust requirements.

DECEMBER 31

GAG CLAUSE ATTESTATIONS DUE

Employers and carriers must submit an attestation of compliance with the gag clause prohibition contained in the Consolidated Appropriations Act (CAA).

CONSUMER DRIVEN HEALTH PLANS

ACA EMPLOYER REPORTING

HIPAA PRIVACY & SECURITY

COBRA PREMIUM BILLING ADMINISTRATION

GOVERNMENT HEALTHCARE PROGRAMS

HEALTH & WELFARE COMPLIANCE

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