COMPLIANCE OVERVIEW

Top Health Plan Compliance Issues for 2024

Employers should be aware of the top compliance issues that impact their health plan coverage for 2024. Some of these compliance issues are established requirements for employers, such as the expanded electronic reporting requirement under the Affordable Care Act (ACA). Other compliance issues are anticipated developments employers should monitor, such as new regulations under the Mental Health Parity and Addiction Equity Act (MHPAEA).

Other top health plan compliance issues employers should be aware of in 2024 include:

- New health plan transparency requirements;
- Ongoing litigation regarding the ACA's requirement to cover preventive care services without cost sharing;
- Possible expansion of the ACA's contraceptive coverage mandate; and
- Proposed legislation at state and federal levels to regulate pharmacy benefit managers (PBMs).

LINKS AND RESOURCES

- Final rule lowering the threshold for electronic ACA reporting beginning in 2024
- Website for submitting prescription drug data collection (RxDC) report
- Proposed rule from August 2023 on MHPAEA compliance

Key Developments - 2024

- Additional transparency requirements for health plans, including expansion of the cost comparison tool
- Continued focus on MHPAEA enforcement
- Federal appeals court decision regarding ACA's coverage mandate for preventive care benefits
- Lowered threshold for ACA electronic reporting

Other Possible Changes

- New state and federal regulation of PBM practices to help control health plan spending
- New state insurance mandates for fully insured health plans
- Revised HIPAA privacy and security rules
- Extension of telehealth exception for high deductible health plans (HDHPs)

New Transparency Requirements

Group health plans and health insurance issuers are subject to many requirements designed to increase health care transparency and protect consumers against surprise medical bills. In general, most employers rely on their issuers, third-party administrators (TPAs) and other service providers to satisfy many of these requirements, including the obligations to provide machine-readable files (MRFs) and a cost comparison tool and submit detailed reports on prescription drug spending. Employers should confirm that their written agreements with their issuers, TPAs or other service providers have been updated to address this compliance responsibility. In addition, employers should monitor their service providers' compliance with federal transparency requirements.

Employers should watch for additional transparency guidance in 2024, including guidance on the currently delayed requirement to provide advanced explanations of benefits (EOBs) and possibly new transparency legislation. In addition, employers should be aware of the following transparency requirements for 2024:

- **Cost comparison tool:** For plan years beginning in 2023, health plans and issuers were required to make an internet-based price comparison tool available for 500 shoppable items, services and drugs. For plan years beginning in 2024, the internet-based price comparison tool must be expanded to cover all covered items, services and drugs.
- **MRFs:** Non-grandfathered health plans and issuers must publicly post three MRFs regarding in-network provider rates, out-of-network allowed amounts and billed charges, and prescription drug rates and prices. Federal agencies have ended an enforcement delay for posting the prescription drug file. Future guidance will specify a timeline for complying with this requirement.
- **Prescription drug reporting:** Health plans and issuers must report information about prescription drugs and health care spending to the federal government annually. This reporting process is referred to as the "prescription drug data collection" (or "RxDC report"). The annual deadline is June 1, which means that the RxDC report is due by June 1, 2024, covering data for 2023. However, because June 1, 2024, is a Saturday, this deadline may be extended to the next business day, which is June 3, 2024.
- **Gag clause attestations:** Health plans and issuers must annually submit an attestation of compliance with the federal prohibition on gag clauses. The gag clause attestation is due by Dec. 31 of each year.

Mental Health Parity Compliance

MHPAEA generally prevents health plans and issuers that provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical coverage. MHPAEA's parity requirements apply to health plans sponsored by employers with more than 50 employees. However, due to an ACA reform, insured health plans in the small group market must also comply with MHPAEA's parity requirements for MH/SUD benefits.

In recent years, the U.S. Department of Labor (DOL) has made MHPAEA compliance a **top enforcement priority**, with a primary focus being MHPAEA's parity requirements for nonquantitative treatment limitations (NQTLs). NQTLs are generally health plan provisions that impose nonnumerical limits on the scope or duration of benefits, such as prior authorization requirements, step therapy and provider reimbursement rates. MHPAEA requires health plans and issuers to conduct **comparative analyses** of the NQTLs used for medical/surgical benefits compared to MH/SUD benefits. These analyses must contain a detailed, written and reasoned explanation of the specific plan terms and practices at issue and

include the basis for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA. Plans and issuers must make their comparative analyses available to the federal government or applicable state authorities upon request.

In addition, a proposed rule was issued in August 2023 that, if finalized, would make extensive changes to MHPAEA's requirements, especially those for NQTLs. To evaluate parity, the proposed rule would require health plans and issuers to collect, evaluate and consider relevant data on access to MH/SUD coverage relative to access to medical/surgical coverage instead of relying on descriptions of coverage. The proposed rule would also impose a special rule for NQTLs related to network composition and establish additional standards for comparative analysis.

Considering the DOL's continuing MHPAEA enforcement efforts in 2024, employers should consider taking the following steps:

- Reach out to their issuers or TPAs to confirm that a comparative analysis has been completed for their health plan's NQTLs and that it is updated to reflect terms and coverage for 2024;
- Monitor any new legislation or regulatory guidance on MHPAEA compliance in 2024, including the issuance of a final rule;
- Watch for warning signs of problematic NQTLs, such as fail-first protocols or written treatment plan requirements; and
- Consider MHPAEA's parity requirements before making any changes to the plan's coverage of medical/surgical benefits or MH/SUD benefits.

Preventive Care Benefits

The ACA requires non-grandfathered health plans and issuers to cover a broad range of preventive care services without charging copayments, coinsurance or deductibles when the services are delivered by in-network providers. The scope of this coverage mandate changes somewhat from year to year as preventive care guidelines are updated. To prepare for each upcoming plan year, health plans and issuers should update their first-dollar coverage of preventive care services to incorporate any new guidelines.

In addition to these routine updates, employers should be aware of recent developments that may impact their preventive care coverage for 2024 and beyond. These developments include:

- The end of certain coverage requirements related to the COVID-19 pandemic;
- Ongoing litigation regarding a key part of the ACA's preventive care mandate; and
- Signals from the Biden administration that it may expand access to contraceptive coverage.

Coverage Changes Related to COVID-19

Because the COVID-19 public health emergency has ended, health plans are no longer required to cover COVID-19 diagnostic tests and related services without cost sharing. Health plans are still required to cover COVID-19 immunizations without cost sharing, but this coverage requirement can now be limited to in-network providers. Employers should determine how these changes impact their coverage of COVID-19 testing and immunizations for 2024 and make sure any coverage changes are communicated to plan participants.

Ongoing Litigation

In March 2023, the U.S. District Court for the Northern District of Texas struck down a key component of the ACA's preventive care mandate as unconstitutional. More specifically, the District Court ruled that preventive care coverage

requirements based on an A or B rating by the U.S. Preventive Services Task Force on or after March 23, 2010, violate the U.S. Constitution. The court also ruled that the requirement to provide first-dollar coverage for preexposure prophylaxis (PrEP) drugs used by persons at high risk of getting HIV violates the Religious Freedom Restoration Act.

The Biden administration appealed the District Court's decision to the 5th U.S. Circuit Court of Appeals. It is uncertain when the 5th Circuit will issue its decision and whether it will reverse or uphold the District Court's ruling. However, for now, non-grandfathered health plans and issuers must continue to cover, without cost sharing, the full range of preventive care services required by the ACA.

If the 5th Circuit agrees that a key component of the ACA's preventive care mandate is unconstitutional, employers will want to consult with their issuers or TPAs to assess the impact on their health coverage. The impact may not be immediate, as making significant midyear changes to plan coverage is unusual and typically triggers a 60-day advance notice requirement to participants. Also, employers may decide to continue providing first-dollar coverage for the full range of preventive care services to help control spending on preventable chronic conditions down the road.

Contraceptive Coverage

The scope of the ACA's preventive care mandate may expand in 2024 as the federal government looks for ways to improve access to contraceptives. Federal agencies have indicated that they may expand the ACA's preventive care mandate to include over-the-counter (OTC) preventive products. In July 2023, the U.S. Food and Drug Administration approved the first nonprescription daily oral contraceptive. This drug, called Opill, is expected to become available in stores and online in early 2024. Current guidance requires coverage for OTC preventive products without cost sharing only when they are prescribed by a health care provider. In 2024, employers should watch for any changes regarding coverage of OTC preventive products and make any necessary adjustments to their health plan coverage.

In addition, the Biden administration has indicated that it wants to expand access to contraceptives by narrowing the exemptions to the ACA's contraceptive coverage mandate. Under the ACA, churches and houses of worship are not required to cover contraceptives. Also, current guidance exempts certain employers from covering contraceptives if they object to this coverage based on sincerely held religious beliefs or moral convictions. In January 2023, federal agencies released a proposed rule that would rescind the moral exemption to covering contraceptives but retain the religious exemption. Employers who rely on the moral exemption to cover contraceptives should monitor the release of a final rule in 2024 and adjust their health coverage going forward, if necessary.

Expanded Electronic Filing Requirement for ACA Returns

The ACA requires applicable large employers (ALEs) and employers with self-insured health plans to report information on their health coverage to the IRS and covered individuals. ALEs report health coverage information using Forms 1094-C and 1095-C, while self-insured employers that are not ALEs use Forms 1094-B and 1095-B to report health coverage information.

Before 2024, employers that filed fewer than 250 individual statements under the ACA's reporting rules could file their returns on paper. However, beginning in 2024, paper filing will only be available to employers who file **fewer than 10 information returns** with the IRS for the year. Due to the lowered threshold, only the smallest employers will be permitted to file using paper returns. Reporting entities must aggregate most information returns, such as Forms W-2 and 1099, to determine if they meet the 10-return threshold for mandatory electronic filing. A hardship waiver may be requested from the electronic filing requirement by submitting Form 8508 to the IRS.

Currently, electronic filing is done using the ACA Information Returns (AIR) Program. Although employers can use the AIR Program to file their own ACA returns electronically, many will rely on outside vendors, such as payroll processors, for electronic reporting due to the AIR Program's complexity.

Employers that have filed paper returns in the past should begin to explore their options for electronic ACA reporting. The normal deadline for electronic ACA reporting is March 31 each year. However, since March 31, 2024, is a Sunday, electronic returns must be filed by the next business day, which is **April 1, 2024**.

Telehealth and HDHPs

To be eligible for health savings account (HSA) contributions, individuals cannot be covered under a health plan that provides benefits, except preventive care benefits, before the minimum deductible for an HDHP is satisfied for the year. Generally, telehealth programs that provide free or reduced-cost medical benefits before the HDHP deductible is satisfied are disqualifying coverage for purposes of HSA eligibility.

However, effective Jan. 1, 2020, the CARES Act allowed HDHPs to provide benefits for telehealth or other remote care services before plan deductibles were met. This relief applied for plan years beginning before Jan. 1, 2022. Additional legislation extended this first-dollar coverage for telehealth services to plan years beginning before Jan. 1, 2025. Without another extension, the relief will expire on Dec. 31, 2024, for calendar-year plans (and during 2025 for non-calendar-year plans).

Bipartisan legislation has been introduced in Congress that would make this telehealth exception permanent. However, the outlook for the proposed legislation is uncertain. Employers with HDHPs that offer no-deductible (or low-deductible) telehealth services should watch for developments and make any necessary changes to their health plan coverage going forward.

Other Potential Developments

Other legislative and regulatory developments are possible in 2024. These would impact health plan coverage in the future. For example, these developments may include:

- New state and federal oversight of PBMs to help control health care spending, such as requirements for applying drug discounts and rebates and prohibitions on spread pricing (which occurs when PBMs keep the difference between actual pharmacy charges and the higher negotiated payments from health plans);
- New state insurance coverage mandates for fully insured health plans, such as cost-sharing caps on insulin and mandated coverage requirements for fertility treatments, gender-affirming care, abortion-related services and substance use disorder treatment; and
- Changes to the HIPAA privacy and security rules, which may require updates to HIPAA policies, notices and business associate agreements.