BENEFITS INSIDER

Volume 350, September 16, 2024
(covering news from September 1-15, 2024)

The ***Benefits Insider*** is a bimonthly member exclusive publication prepared for WEB members by the American Benefits Council ("the Council"), a premiere benefits advocacy organization based in Washington, DC. This newsletter provides the latest news and analysis on the most important benefits-related policy matters in Congress, executive branch agencies and the federal judiciary.

Please note: any views or opinions expressed in these stories represent the advocacy positions of the American Benefits Council and its membership. They do not necessarily reflect the views of WEB or its membership. To inquire about membership with the American Benefits Council, contact Deanna Johnson at (202) 289-6700 or djohnson@abcstaff.org.

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RECENT REGULATORY ACTIVITY

Final Mental Health Parity Rules Released

You Need to Know:

- Final mental health parity regulations were released on September 9. These are important rules for plan sponsors to understand.
- Some parts of the rule are effective for plan years beginning in 2025 but many other provisions of the rules have a delayed effective date beginning in 2026.
- The Council raised to the agencies several substantial concerns regarding aspects of the proposed rules. It appears that some, but not all, of the concerns have been addressed favorably for plan sponsors in the final rule.

On Monday, September 9, the U.S. departments of Treasury, Labor and Health and Human Services, ("the tri-agencies") released much-anticipated final regulations under the Mental Health Parity and Addiction Equity Act (MHPAEA):

- Final Rules
- Fact Sheet
- New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Plans and Issuers
- News Release

The final regulations, which are almost 550 pages long (unpublished version), include amendments to the current MHPAEA final regulations (issued in 2013), focused on requirements related to nonquantitative treatment limitations (NQTLs) (*e.g.*, prior authorization) imposed on mental health and substance use disorder benefits, as compared to medical/surgical benefits. The final regulations also address the content requirements of the NQTL comparative analyses required by the Consolidated Appropriations Act, 2021 (CAA), in which plans must document compliance with the NQTL rules under MHPAEA.

The Council raised several significant concerns regarding the proposed regulations. From a first look, it appears some of the top concerns raised by the Council were addressed.

For example, the application of the Substantially All/Predominant mathematical test to NQTLs was *not* finalized and the fiduciary certification was modified to require certification confirming the fiduciary's engagement in a prudent process to select and monitor service providers performing a comparative analysis for the plan, instead of a certification of compliance with the NQTL requirements. This is welcome news.

However, other concerns expressed by the Council were not reflected in a changed final rule; for example, the tri-agencies finalized the proposed meaningful benefit requirement without much additional detail about what is required and they did not provide an exhaustive list of NQTLs that would require a comparative analysis under the final rule.

In terms of the implementation timeframe, most of the rule is effective for plan years beginning in January 1, 2025, while other parts, such as the new meaningful benefits standard, the prohibition on discriminatory factors, and the data evaluation requirements have a delayed effective date of the first plan year beginning on or after January 1, 2026.

In addition to the final regulations, fact sheets and press release (The release did not include a new MHPAEA report to Congress nor did it include an updated MHPAEA Self-Compliance Tool), the tri-agencies indicate that more guidance is forthcoming; for example, they intend to update the MHPAEA Self-Compliance Tool and provide additional information on the data plans and issuers should collect and evaluate.

As previously reported, the Council has strongly advocated for MHPAEA guidance over the last several years, focused on the NQTL comparative analysis requirement in the CAA. We have done so due to the extensive confusion among plan sponsors as to how to comply with this new requirement, notwithstanding employers' strong commitment to mental health coverage and compliance with mental health parity. We have also worked extensively with agency staff, formally and informally, to address concerns with the proposed regulations.

Council Voices Support for Hospital Price Transparency, Site-Neutral Payments and Quality Reporting in Comments to HHS

You Need to Know:

- In response to a wide-ranging set of proposed regulations on Medicare, the Council emphasized its support for hospital price transparency and site-neutral payment reform, even though those issues were not addressed in the proposed regulations.
- The Council also expressed support for new, proposed reporting requirements for hospitals related to quality and health equity.

On September 9, the American Benefits Council filed written comments with the U.S. Department of Health and Human Services (HHS) in response to an annual Medicare-related notice generally referred to as the Medicare Outpatient Prospective Payment System (OPPS) rule for 2025.

The rule largely covers Medicare-specific topics outside the Council's purview, but we provided comments on several issues relevant to employer plan sponsors, including:

Hospital Price Transparency: Beginning in 2021, hospitals were required to publicly disclose their standard charges (including negotiated rates). Over the last several years, there have been reports of widespread noncompliance by hospitals, and HHS has made changes to address this, including by increasing noncompliance penalties. Because historically HHS has addressed hospital price transparency in the OPPS rule (although they did not in this year), the Council took this opportunity to reiterate our support for the hospital price transparency rules and to urge HHS to enhance its enforcement efforts and to consider increasing penalties to support widespread compliance. The letter also asks HHS for further guidance to ensure that files that are published are usable and clear.

Site-Neutral Payments: In the past, as part of the annual OPPS rulemaking, HHS has implemented rules that support site-neutral payment policy. That is, HHS rules have provided that under Medicare, hospital-based off-campus outpatient office visits will be reimbursed under the Medicare equivalent to what a standalone physician's office will be reimbursed. (Historically, Medicare has paid more for items and services furnished in hospital-based settings, even off-campus). We have been supportive of these efforts to lower health care costs and to address provider consolidation. As such, although this year's OPPS rule does not address this issue, the Council expressed our support for site-neutral payment reform generally and asked HHS to consider future expansions to the policy, including to other items and services and other settings.

Medicare Quality Reporting and Health Equity: In the 2025 OPPS rule, HHS proposed to add several new measures to its hospital outpatient quality reporting system. Under this long-standing program, hospitals must report certain information to HHS to receive their full Medicare reimbursement rate and HHS uses the information to provide public facing quality information. The new measures proposed in the 2025 OPPS rule include several measures aimed at health equity and social drivers of health. The Council's letter expressed support for the addition of these health equity related measures to the hospital quality reporting system, including because the information will be reflected in public quality reports that all stakeholders can use.

Also submitting comments on the OPPS rule was Consumers First, a diverse coalition of health policy stakeholders, of which the Council is a steering committee member. The Consumers First comment letter includes comments consistent with those made in the Council's letter, supporting hospital price transparency, site-neutral payments and health equity.

IRS Announces 2025 Adjustment to Employer Mandate Affordability Percentage

You Need to Know:

- The percentage figure used to determine health insurance affordability under the ACA's employer mandate has been updated for 2025, affecting how much an employer needs to contribute to health coverage to avoid an employer mandate penalty.
- The 2025 percentage has increased from the all-time low 2024 percentage but still remains historically low.

As it does each year, the Internal Revenue Service (IRS) **has announced** the affordability percentage that will apply for purposes of the Affordable Care Act (ACA) employer health insurance mandate for plan years beginning in 2025. The applicable percentage has increased from 8.39% in 2024 to 9.02% in 2025.

In general, under the employer mandate, large employers must offer coverage to their full-time employees that is affordable and that provides minimum value. An offer of coverage to a full-time employee is considered affordable if the employee's required contribution for self-only coverage is no more than 9.5% (as annually adjusted) of the employee's household income (HHI). Because the percentage sets out the ceiling on what *the employee* can contribute (as a % of their HHI), the lower the affordability percentage, the more the employer needs to contribute in

order to ensure the offer of coverage is affordable. Under final regulations governing the ACA employer mandate, because employers generally do not have access to employees' HHI, affordability safe harbors were provided allowing employers to base affordability on Form W-2 wages, rate of pay or the federal poverty line.

Each year, the affordability percentage (*i.e.*, 9.5%) is adjusted based on various inflation factors. Since the employer mandate has been in effect, the percentage has changed each year, going up and down. (See IRS FAQs, Q&A 40 for a historical list).

Under IRS Revenue Procedure 2024-35, for plan years beginning in 2025, the percentage will be 9.02%. This is an increase from last year (for which the applicable percentage was 8.39%) but remains the second-lowest percentage that has applied since the employer mandate took effect.

Large employers should confirm that offers of coverage will continue to be affordable and make necessary adjustments. (For more information on the other limited purposes for which the 9.5% (as adjusted) is relevant under the employer mandate see Notice 2015-87, Q&A 12.)

IRS Seeks Input on New Saver's Match Under SECURE 2.0 Act

You Need to Know:

- The IRS and Treasury Department have issued a request for information on the implementation of the new Saver's Match under the SECURE 2.0 Act.
- The IRS is seeking input from stakeholders on logistical and procedural considerations to ensure a smooth rollout in 2027.

The U.S. Treasury Department (Treasury) and Internal Revenue Service (IRS) have issued a request for information (RFI) on implementing the Saver's Match provision of the SECURE 2.0 Act, which will convert the existing Saver's Credit into a refundable tax credit beginning in 2027. The IRS is also asking for input on promoting awareness of the new credit and plans to submit a report to Congress by July 1, 2026, outlining these efforts.

The Saver's Match will provide eligible individuals with a refundable tax credit of up to $1,000, deposited directly into their designated retirement savings accounts. Eligible contributions include those to traditional and Roth IRAs, 401(k) plans, 403(b) plans, SIMPLE IRAs, SEP plans, and others. However, the Saver's Match cannot be contributed to a Roth IRA or designated Roth account, which may present a challenge for many eligible individuals who currently use these accounts.

To facilitate the implementation of the Saver's Match, the IRS is considering several logistical and procedural measures, including creating a system to identify eligible accounts and ensuring proper fund distribution. Additionally, the agency is seeking ways to streamline the process, such as simplifying IRA account openings and determining default destinations for mistaken contributions.

The RFI, which includes 29 questions across various topics, such as eligibility criteria, fund designation and recovery tax for early distributions, is designed to gather feedback from

stakeholders, including plan sponsors, tax preparers, and organizations serving lower-income individuals. Comments are due by November 4, 2024.

The IRS emphasizes the need for a strategic approach to minimize costs, reduce burdens and encourage plans to accept the Saver's Match contributions. The RFI is part of ongoing efforts to ensure that the new program is accessible and efficient for both plan sponsors and eligible individuals.

The Council has been in discussions with Treasury about the Saver's Match, including having senior Treasury officials speak to our Retirement Income Task Force earlier this year.

The Council will continue to work closely with the agencies to provide input on behalf of plan sponsors and ensure the successful rollout of the Saver's Match program.

RECENT LEGISLATIVE ACTIVITY

Council Urges House Subcommittee: Preserve Employer-Provided Health Coverage by Protecting ERISA, Lowering Costs

You Need to Know:

- In congressional testimony on September 10, the Council urged lawmakers to protect employer-sponsored health coverage by preserving ERISA's preemption standard and working to lower costs through greater transparency and competition.
- The Council promoted two cost-saving health measures slated to be considered by a key House committee on September 11.
- During the hearing, Representative Joe Courtney offered a strong defense of the current tax incentives for employer-sponsored health coverage.

In testimony before the U.S. House of Representatives Committee on Education and the Workforce Subcommittee on Health, Employment, Labor and Pensions on September 10, Ilyse Schuman, the American Benefits Council's senior vice president, health and paid leave policy, offered a pathway for preserving employer-provided health coverage.

The hearing, ERISA's 50th Anniversary: The Value of Employer-Sponsored Health Benefits, was intended to spotlight the 50th anniversary of the landmark benefits law, which has made possible the successful employer-provided health coverage system.

"Employer-sponsored health insurance brings tremendous value to working families, businesses, taxpayers, the economy and the health care system as a whole," Schuman said in her testimony. To sustain this value, she recommended:

- Preserving ERISA's preemption provisions, which protect employer-sponsored plans from a costly and complex patchwork of state regulations. "ERISA's preemption provisions have been the cornerstone of employer-sponsored health benefits for 50 years, enabling nationwide uniformity and equitable coverage," Schuman said. "Yet,

these provisions are under assault, threatening the ability of employers to offer consistent, high-value coverage to working families."
- Supporting transparency and competition in the health care market, by slowing provider consolidation and advancing policies that ensure access to meaningful price and quality data. Schuman specifically recommended passage of the Lower Costs, More Transparency Act (H.R. 5378) and two other measures scheduled for full committee markup on September 11 (see below).
- Opposing burdensome federal regulations that add cost and complexity to group health plans without providing commensurate value.

Also testifying before the subcommittee were:

- Holly Wade, executive director of the National Federation of Independent Business Research Center
- Anthony Wright, executive director of Families USA, a member organization of the Alliance to Fight for Health Care (a multi-stakeholder coalition organized by the Council to promote and defend employer-provided coverage)
- Paul Fronstin, director of health benefits research for the Employee Benefit Research Institute, with whom the Council has been working throughout the year on programs educating congressional staff on the importance of ERISA

During the question-and-answer period, subcommittee members raised a number of questions related to employer-sponsored health coverage.

Representative Joe Courtney (D-CT), with whom the Council worked closely as he led the congressional effort to repeal the Affordable Care Act's 40% "Cadillac tax" on employer-sponsored coverage, offered a strong defense of the current-law tax exclusion on the value of employer coverage. The highly influential Republican Study Committee (RSC) and other conservative groups have proposed "capping" the exclusion at an undetermined level. Courtney pushed back strenuously on this proposal, saying it would amount to a tax increase on employers and employees.

Representative Aaron Bean (R-FL) asked about the costs related to hidden hospital facility fees in relation to telemedicine, mentioning legislation he's working on to limit hidden fees and add-ons around telehealth (see below), a position strongly supported by the Council.

"Allowing hospitals to charge a facility fee for telehealth appointments is a prime example of a payment distortion that's increasing healthcare costs for employers and for patients," Shuman said. "These services are delivered via telehealth, but the facility is a phantom, and the fee is very real. We strongly support legislation that would protect group health plans from having to pay facility fees for telehealth services. It just doesn't make sense."

On September 11, the full Education and the Workforce Committee is scheduled to review and vote on two health care bills endorsed by Schuman in the Council's testimony:

- The Healthy Competition for Better Care Act (H.R. 3120), sponsored by Representative Michelle Steel (R-CA), would increase competition in the health care provider market

and promote lower costs by restricting anti-competitive contract terms like "anti-steering" or "anti-tiering" provisions and "all-or-nothing" or "most-favored nation" clauses.
- The Transparent Telehealth Bills Act (H.R. 9457), sponsored by subcommittee member Bean, would prohibit increased "facility fee" payments for telehealth services furnished by providers located at hospital facilities.

House Committee Approves Measures, Supported by Council, to Lower Health Care Costs

You Need to Know:

- A key House committee advanced legislation that would help lower health care costs by addressing anticompetitive practices by providers.
- The Council offered its strong support for the two bills and is pushing for enactment of these and similar measures before the end of the year.

The U.S. House of Representatives Committee on Education and the Workforce approved two measures on September 11 that would help lower health care costs by addressing anticompetitive practices by hospital systems. Prior to the committee action, the Council circulated **a letter offering strong support for this legislation**.

Healthy Competition for Better Care Act

The committee approved a substitute amendment to the Healthy Competition for Better Care Act (H.R. 3120), by voice vote.

H.R. 3120, sponsored by Representative Michelle Steel (R-CA), would increase competition in the health care provider market and promote lower costs by restricting anti-competitive contract terms like "anti-steering" or "anti-tiering" provisions and "all-or-nothing" or "most-favored nation" clauses.

The Council's letter explained how, as hospital consolidation increases, these anti-competitive contracting provisions have become more prevalent and have had a negative impact for more employers and workers. "With such contracting terms in place, the employer's hands are tied in their efforts to promote higher-value health care and employees are bound more tightly to higher-cost and/or lower quality providers."

During debate, the committee's ranking Democrat, Bobby Scott (D-VA), offered support for the legislation in principle but expressed concern that "the exemptions provided … are broad and threaten to undermine the effectiveness of the policy." He also criticized a provision of the bill that would allow a state to grandfather a specific contract that was entered into on a specified date. The provision differs from a much broader provision contained in the Bipartisan Primary Care and Health Workforce Act (S. 2840, approved by the Senate Health, Education, Labor and Pensions Committee in 2023) allowing states to opt-out, which raised serious issues about the erosion of ERISA preemption.

Transparent Telehealth Bills Act

The committee also approved a substitute amendment to the Transparent Telehealth Bills Act (H.R. 9457) by a unanimous, bipartisan vote, after an additional amendment was adopted.

H.R. 9457, sponsored by Representative Aaron Bean (R-FL), would prohibit increased "facility fee" payments for telehealth services furnished by providers located at hospital facilities.

"Employers strongly support policies that allow them to increase access to affordable medical and mental health care via telehealth," the Council wrote. "However, allowing hospital "facility fees" to be charged for telehealth appointments is precisely the type of payment distortion and obtuse billing practice that increases costs for patients and employers."

During discussion of the bill, Bean cited the testimony of Ilyse Schuman, the Council's senior vice president, health and paid leave policy, before the committee's health, employment, labor and pensions subcommittee on September 10.

Scott, while again stating his support for the goal of the bill – recognizing increased facility fees as a problematic symptom of hospital system consolidation – voiced his objection to the mechanics of the bill, which he said would not prohibit providers from charging the fees but would simply insulate insurers from paying them, potentially passing costs to consumers.

Subsequent to Scott's comments and prior to the vote, the committee approved an amendment by Representative Jahana Hayes (D-CT), preventing health care facilities outright from charging consumers a separate facility fee. Under the bill as amended, facility fees for telehealth would only be permitted when there is no professional fee available to the billing provider.

Other Bills

During the same markup session, the committee also approved – on a party-line vote – a Congressional Review Act resolution to negate the Biden administration's final rule limiting access to Association Health Plans (AHPs). The Council did not take a position on this resolution.

The committee also approved legislation related to parental rights, campus hazing, child abuse prevention and hazing.

The Council continues to push Congress to enact the Lower Costs, More Transparency Act (H.R. 5378) and other measures to lower health care costs before the end of the congressional session. H.R. 5378 was approved by the full House earlier this year.

MISCELLANEOUS

Alliance to Fight for Health Care Releases Public Opinion Research Showing Support for Health Care Tax Incentives, Measures to Lower Health Costs

You Need to Know:

- The Alliance to Fight for Health Care, a coalition founded and managed by the Council, released public opinion polling supporting a number of the Council's policy priorities.
- The poll shows strong public support for the current law tax incentives for employer-sponsored health coverage as well as a number of proposals to increase competition, enhance transparency and lower costs.

A recent poll by the Winston Group on behalf of the **Alliance to Fight for Health Care** shows strong voter support for key elements of the American Benefits Council's health policy agenda.

The Alliance to Fight for Health Care was originally established by the Council as a diverse, multistakeholder coalition devoted to repeal of the Affordable Care Act's 40% "Cadillac Tax" on employer-provided health coverage. After repeal was achieved, the coalition broadened its charter to the promotion and protection of employer coverage.

The Winston Group, a strategic planning and survey research firm in Washington, D.C., surveyed 1,200 registered voters nationwide (including 1,107 with insurance) in June 2024 and found:

- By a three-to-one margin, voters oppose proposals to impose taxes on employer-provided health plans. This opposition was bipartisan, with 61% of Republicans, 62% of Independents, and 52% of Democrats opposing the proposal. As Council President James Klein said in a news release supporting the release of the poll, "In recent months, we have heard again a call to eliminate or 'cap' the employee tax exclusion on health coverage. This isn't just bad policy – the Winston Group poll shows that this would be a serious political liability."
- More than three-quarters (78%) of registered voters expressed satisfaction with their employer-sponsored health coverage. By a margin of more than three to one (64% to 21%), voters with employer-sponsored health coverage preferred a system where companies provide comprehensive health coverage options, rather than a stipend for employees to shop for their own health insurance in the individual market. Only 7% of voters with employer-sponsored health coverage preferred a system where employers do not provide health benefits at all.
- While voters are generally satisfied with their health insurance (the poll also underscores deep concerns about health care costs. The economy/inflation is the top issue for 38% of voters, and they believe that over the next year, health care costs will continue to rise (66%).
- 90% of voters with employer-sponsored health insurance think it is important for Congress to take action **t**his year to lower health care costs (54% of those voters say that this is very important)
- Currently, the cost of health care services and procedures differ based on where the service or procedure is administered, with services at hospitals or hospital-owned doctor's offices costing more than the same services at independent doctor's offices or at ambulatory surgical centers. The poll found that 72% of voters with employer-sponsored coverage believe health care could be more affordable by having services performed at less expensive settings when they can be done so safely – for instance performing minor outpatient surgery in a clinic rather than a hospital to lower the cost of the procedure (often referred to as "site-neutral payment reform").

- Voters also believe Congress should require health care providers to accurately report where a service actually occurred so hospitals cannot charge extra fees for services performed via telehealth or at clinics or doctors' offices, which costs taxpayers billions of dollars in extra fees. The poll findings show 82% of voters oppose hospital facility fees for care received via telemedicine appointments.
- In addition, 81% of voters indicate that a top priority for Congress should be allowing more preventive care for chronic diseases to be covered by health insurance even before patients meet their annual out-of-pocket deductible. The Council and the Alliance strongly support legislation that would allow employers and health plans to offer more chronic disease prevention pre-deductible, and has urged enactment of H.R. 3800, the Chronic Disease Flexible Coverage Act.

"As we celebrate ERISA's 50th anniversary, it is vital that policymakers recognize that the law makes possible affordable, high-quality employer-provided coverage enjoyed by more than half of all Americans. Two-thirds of voters believe health care is one of the highest priorities before Congress. It is imperative that lawmakers work within ERISA's framework to lower health care costs for working families," Klein concluded.