Navigating the Surprise Billing Payment Dispute Process: Tri-Agencies Issue Proposed Rule

By Kate Belyayeva

In 2020, the federal government signed into law the Surprise Billing Act, officially known as the No Surprises Act, (the "Act") in an effort to address surprise medical billing and establish certain patient protections, price transparency measures, and the federal independent dispute resolution ("IDR") process. The federal IDR process is a crucial component of the Act and is designed to resolve payment disputes between insurers and healthcare providers.

On October 27, 2023, the tri-agencies—the Departments of Health and Human Services ("HHS"), the Department of Labor, and the Department of the Treasury (collectively, the "Departments")—together with the Office of Personnel Management released a proposed rule on the Act and the associated federal IDR process. The proposed rule aims at enhancing various aspects of the Act, as detailed below. For a full reading of the proposed rule, please see:

https://www.federalregister.gov/documents/2023/11/03/2023-23716/federal-independent-dispute-resolution-operations

Federal IDR Process

The federal IDR process is initiated when either the healthcare provider or the insurer submits a request for dispute resolution to HHS. The request must include all relevant information (i.e., the charges and payment offers). As the next step, HHS will assign an IDR entity, which comprises of healthcare experts, to evaluate the dispute and make a determination on the appropriate payment amount. Multiple factors are to be considered in review, including the provider's quality and the complexity of the case. The IDR entity's determination is binding on the payment amount and thus both the healthcare provider and the insurer are legally bound to abide by it. As a result, the patient's bill will be adjusted in accordance with the IDR entity's decision.

Proposed Rule

The proposed rule (if finalized) will impact the following aspects of medical surprise billing and the Act:

- *Communication Between Payers* and Providers: Payers and providers have expressed challenges relating to communication and acquisition of the information necessary for resolving disputes. To improve information exchange and ensure

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Proposed Rule Cont.

- *Open Negotiation and IDR Initiation:* The Act and the related regulations established a 30-business-day open negotiation period to give the involved parties a chance to agree on a payment rate without the need of the federal IDR process. One of the proposals touches upon several modifications to the open negotiation process with the aim of promoting a pre-IDR engagement among parties. Under the proposed rule, when a party commences open negotiation, the party must submit a notice along with a copy of the remittance advice or payment denial notice to the other party and the Departments through the federal IDR portal. The Departments are also considering the addition of new content requirements for the open negotiation notice, such as the plan type, the location service, and the claim number for identification purposes, as well the implementation of an open negotiation response notice.

- *IDR Eligibility and Administrative Fees:* Determining eligibility for the federal IDR process is challenging and time-consuming, which often leads to a delay in timely decisions on payment disputes. The proposed rule intends to rectify this issue by introducing a "Departmental eligibility review process" to be invoked during periods of high volume and thus expediting the resolution of disputes. With regard to the statutorily required non-refundable administrative fees, the Departments propose a direct collection of such fees from the disputing parties and set forth requirements for when the parties would be required to pay them. Penalties for failure to pay the fees are also being considered by the Departments. In addition, the Departments are contemplating reduced fees for low-dollar disputes and non-initiating parties in ineligible disputes.

- *Batching*: Certain stakeholders have suggested "batching," which is a process by which multiple items or services may be combined within a single dispute in order to enhance efficiency and reduce costs of the federal IDR process. The Departments generally agree and recommend a new set of provisions for batching that would permit eligible items and services to be grouped together. Note that, under the proposed rule, batching would be permitted only with relation to certain IDR items and services.

Impact on Healthcare Providers and Insurers

The financial burden of surprise medical billing can be overwhelming to patients; however, the healthcare providers and insurers also suffer at the hand of this discrepancy in the system. The aforementioned parties generally celebrate the proposed rule given the introduction of a level of certainty in billing disputes. While the full amount of payment is not guaranteed, all parties benefit from the federal IDR process as it prevents them from being stuck with either the entire bill or no payment at all. A reasonable payment based on the median rates in the area reduces the financial uncertainty and administrative burdens that often accompany payment disputes. Generally, the changes under the proposed rule seek to avoid creating new operational complexities and promote efficiency and cost reduction for all parties involved.

Conclusion

The federal IDR process within the Act is a major step in the right direction to address the issue of payment disputes. The federal IDR process does not intend to and cannot possibly completely eradicate surprise medical billing and the issues associated with payment disputes; however, the proposed rule will inevitably help stabilize the process and prevent significant fluctuations in payments and medical debt.

Federal Court Strikes Down HHS Rule on Copay Accumulator Programs

By Claire Martin

Last month, in *HIV and Hepatitis Policy Institute et al v. HHS*, Case No. 1:22-cv-02604-JDB (D.C. Sept. 29, 2034), the U.S. District Court for the District of Columbia struck down a Department of Health and Human Services ("HHS") rule established under the Trump Administration that permitted (but did not require) health plans and insurers to decline to count towards a health plan participant's annual cost-sharing obligations financial support provided by drug manufacturers to help participants pay for specific prescription drugs (e.g., discount cards, coupons, copay assistance programs). These "copay accumulator" programs are often used by insurers and pharmacy benefit managers ("PBMs") as a way to control drug spending and prevent overutilization; however, they can operate to make participants pay more out-of-pocket for certain prescription drugs.

As background, the Affordable Care Act ("ACA") sets an annual cap on the amount that plans and insurers can require participants to pay out of pocket for their medical expenses. Once this annual cost-sharing limit is reached, the health plan and/or insurer is responsible for covering the participant's remaining medical expenses for the year. For this purpose, the ACA defines "cost sharing" to include: (i) deductibles, coinsurance, copayments, or similar charges; and (ii) any other expenditure required of an insured individual, which is a qualified

medical expense with respect to essential health benefits covered under the health plan.

Drug manufacturers have long provided various forms of assistance to help participants afford their prescription drugs, including discount cards, coupons, and copay assistance programs (wherein the drug manufacturer covers a portion of the patient's cost-sharing obligation in order to assist the participant in meeting the health plan's annual cost-sharing limit). In response to this, plans and insurers began to implement "copay accumulators" as a way to avoid counting drug manufacturer assistance towards a participant's annual cost-sharing obligations. Generally, under these copay accumulator programs, participants are permitted to use the assistance to purchase their prescription drugs, but the value of the assistance is not be credited toward their annual cos-sharing limit. In such cases, once the drug manufacturer assistance is exhausted, participants are still required to satisfy the health plan's cost-sharing limit before the health plan and/or insurer will cover any additional prescription drug costs for the year.

Federal law was silent on this practice until 2019; however, in addition to the ACA's definition of cost sharing, the regulatory definition of "cost sharing" similarly covers "any expenditure required by or on behalf of an enrollee with respect to essential health benefits, which includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services." In 2019, HHS issued guidance on copay accumulators (through the HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 17454 (April 25, 2019) ("2020 NBPP")), which provided that plans and insurers could, unless inconsistent with state law, decline to count the value of any drug manufacturer assistance for drugs that have an "available and medically appropriate generic equivalent" against a participant's annual cost-sharing limit. There was confusion, however, about whether the 2020 NBPP permitted insurers to exclude all drug manufacturer assistance from a participant's annual cost-sharing limit (rather than only for circumstances where a generic equivalent is available). In response, HHS explained that in circumstances where there is no generic equivalent available, drug manufacturer assistance must be counted toward a participant's annual cost-sharing limit. This clarification was not included in the 2020 NBPP, which resulted in further confusion.

Subsequently, in 2020, HHS issued additional guidance (through HHS Notice of Benefit and Payment Parameters for 2021, 85 Fed. Reg. 29164 (May 14, 2020) (the "2021 NBPP") to further clarify its stance on copay accumulators. The 2021 NBPP provided that unless it was inconsistent with state law, plans and insurers could (but are not required to) decline to credit drug manufacturer assistance for specific drugs when calculating whether participants have met their annual cost-sharing obligations (regardless of whether or not the drug had a generic equivalent). Moreover, the 2021 NBPP provided that if plans and insurers elect to credit such assistance, it should be included in the definition of "cost sharing" and considered part of the overall charges incurred by the participant (and vice versa if they elect not to credit assistance). Essentially, the 2021 NBPP left health plans and insurers with the discretion to define "cost sharing" and to apply or not apply assistance toward a health plan participant's annual cost-sharing limit.

Patient advocacy groups thereafter sued HHS and the Centers for Medicare and Medicaid Services seeking to invalidate the 2021 NBPP. The plaintiffs argued that the 2021 NBPP conflicts with the statutory and regulatory definitions of "cost sharing," and the 2021 NBPP is arbitrary and capricious for several different reasons.

The Court sided with the plaintiffs and set aside the 2021 NBPP on the basis that its language is contradictory and conflicts with both the ACA's statutory definition of "cost sharing" and the agencies' preexisting regulatory definition of "cost sharing." First, the Court explained that by authorizing plans and insurers to either count, or not count, assistance toward the annual cost-sharing limit—that is, to treat it as either within or without the definitions of "cost sharing"—the 2021 NBPP adopts two different, contradictory readings of the same statutory and regulatory text and allows the regulated parties to choose their preferred meaning, which is something that the Supreme Court has previously rejected.

Next, the Court explained that because drug manufacturer assistance is "an expenditure" by drug manufacturers made "on behalf of" a participant, the 2021 NBPP's discretion regarding whether assistance is "cost sharing" conflicts with the statutory and regulatory definitions thereof, which cover deductibles, coinsurance, copayments, similar charges, and "any expenditure" required by or made "on behalf of" a participant with respect to essential health benefits.

Following the Court's invalidation of the 2021 NBPP, plans and insurers now must adhere to the 2020 NBPP, which as detailed above, permits the use of copay accumulators for drugs that have a generic equivalent (unless otherwise prohibited by state law). Consequently, plans and insurers are prohibited utilizing copay accumulators for drugs that lack generic equivalents, and in such situations, drug manufacturer assistance must be counted toward the annual cost-sharing limit. The Court also remanded the issue to HHS to allow the agency the opportunity to issue further guidance regarding on co-pay accumulators.

This ruling is a significant win for patient advocacy groups and will impact many employer-sponsored health plans, insurers and PBMs, as well as participants, as it relates copay accumulator programs and prescription drug affordability. Many plans, insurers, and PBMs may have to adjust their current copay accumulator programs to allow participants to count toward their annual cost-sharing limit drug manufacturer assistance for their high-priced specialty drugs that do not have a generic equivalent. Any such changes in this regard will require communications to participants regarding the impact on their cost-sharing obligations. While it is unclear whether there will be an appeal in this case, patient advocacy groups have made it clear they intend to continue to advocate for a comprehensive state and federal level ban on copay

accumulator programs, signaling that this issue is not yet settled.

Direct Contracting Fundamentals for Negotiating with Providers

By Seth Capper

By and large, self-insured group health plan sponsors look to their third party administrators ("TPAs") to establish networks and negotiate rates with providers. Those TPAs are often subsidiaries or divisions of large insurance companies, which offer the same networks and rates consistently across the range of plans they underwrite and service. Consequently, the specific needs of self-insured plan sponsors and their participant populations may be neglected when relying solely on insurer/TPA network arrangements. This is where direct provider contracts can help plan sponsors reduce costs while also potentially increasing the quality of care for certain treatments and procedures.

Overview of Direct Provider Contracts

Over the last decade, it has become increasingly common for self-insured plans to negotiate direct arrangements with healthcare providers—typically, large hospital systems or provider networks—under which the plan and its participants receive care pursuant to customized terms and reimbursement rates. These arrangements may apply to the entire spectrum of health care services for which benefits are provided, or they may be tailored to a specific subset of services, like joint replacements, cardiac procedures, or other high-volume, high-cost procedures.

Direct provider contracts offer self-insured plan sponsors a unique opportunity to gain control over both the quality of care and escalating claims costs. Working directly with providers allows self-insured employers to design an arrangement that is tailored to meet the specific needs of its employee population. At the same time, employers negotiating direct contracts with providers should be aware of a number of potential legal compliance issues and contractual considerations when structuring and negotiating such arrangements.

Compliance and Contractual Considerations

As with any other group health plan, employers with self-insured plans entering into direct provider contracts must ensure that the plan, and thus the direct provider contracts, are designed and administered in accordance with applicable laws, including ERISA, the ACA, HIPAA, the Mental Health Parity and Addiction Equity Act, etc. Employers must be particularly attentive to certain ERISA fiduciary and prohibited transaction concerns. For example, if the provider contracts directly with the self-insured plan to provide plan administrative services, the contract will be subject to ERISA's prohibited transaction rules governing service provider contracts, which generally state that the compensation paid to the provider must be reasonable, and which necessitate that the contract itself must be terminable upon reasonably short notice to prevent the plan from becoming locked into an arrangement that has become disadvantageous to participants.

If the provider assumes certain administrative responsibilities, doing so may make the provider an ERISA fiduciary with respect to the plan and its participants. In such cases, the contract must be structured to ensure that the provider will act in accordance with its fiduciary duties of care and loyalty under ERISA, avoid conflicts of interest, and refrain from participating in prohibited transactions. For example, a fiduciary generally cannot use its authority to cause the plan to pay compensation to itself or to another related party (i.e., fiduciary self-dealing). Accordingly, if any part of claims administration is delegated to the provider, the parties should ensure that the arrangement is structured such that the provider is not permitted to use discretionary claims and appeals authority to direct the use of plan assets to pay itself or related parties.

Some direct provider contracts are designed to create cost savings for the plan and its participants through rebates or "revenue sharing" reimbursements back to the plan sponsor. For example, while the health plan's primary TPA may continue to administer applicable claims and, thus, may continue to apply its own contracted reimbursement rates, the provider may agree to rebate a portion of that reimbursement back to the plan sponsor as part of their direct contract for certain procedures. When direct provider contracts are designed in a way that results in rebates/reimbursements back to the employer, those funds likely should be treated as plan assets, meaning the funds are subject to ERISA's "exclusive benefit rule" (i.e., the funds must be used exclusively to provide benefits and/or to pay for the reasonable expenses of plan administration).

Additionally, there is some risk to the employer that the above rebate/reimbursement arrangements could result in the plan being deemed a "funded" plan. Funded plans are not eligible for the relief from ERISA's trust rules under DOL Technical Release 92-01 or the exemptions from various Form 5500 reporting requirements under 29 CFR §§ 2520.104-20 and 104-44, including most notably the annual audit requirement. Based on available guidance, it is unclear how the DOL would apply the funding rules in this context; however, analogous guidance relating to MLR rebates suggests that a plan receiving plan assets back from a service provider may be able to avoid "funded" plan status by using those plan assets for permissible plan purposes within three months of receipt.

From a contractual perspective, insurers and TPAs with their own provider networks often will design their in-network contracts with providers and service agreements with plans to limit the ability of providers and plan sponsors to enter into direct contracts with one another that may undercut the insurers/TPAs' rates and eat into their revenues. Employers and providers seeking to enter into direct arrangements should carefully review their existing contracts with TPAs/network providers. If entering into a direct provider contract runs afoul of any provision of those contracts, the employer and provider should mutually determine whether their actions constitute

actions constitute breaches of contract, the extent of potential liabilities stemming from those breaches, and what actions may be taken to eliminate the breaches and/or potential liabilities stemming therefrom.

The Upshot

Direct provider contracts can be a great way for self-insured plan sponsors to work with healthcare providers to reduce costs for the plan and participants and potentially create better quality of care, while also increasing revenues for the provider. However, direct provider contracts are complex and require navigating and coordinating relationships between and among the employer, the provider (and, possibly, the TPA). The provider may assume responsibilities and provide services typically provided by TPAs, such as case management, quality improvement, and even member service functions. Thus, an employer will want to be satisfied that the provider has the administrative capacity and expertise necessary to provide such services. In addition, both the employer and provider will want to ensure that their arrangement does not create any compliance failures or contractual breaches, which may expose the parties to potential liabilities from TPA, participant, or other third party litigation or governmental enforcement efforts.

Compliance Corner: When "Voluntary" Alone Is Not Enough: Understanding the Voluntary Plan Safe Harbor Rules

By Claire Martin

As many employer plan sponsors are aware, the Employee Retirement Income Security Act ("ERISA") generally applies to "employee welfare benefit plans", which are any plans, funds or programs established or maintained by an employer for the purpose of providing certain benefits to participants and beneficiaries. ERISA comes with a range of compliance requirements (e.g., fiduciary obligations, plan document and summary plan description requirements, and reporting requirements (i.e., the annual Form 5500)), so it is very important for employer plan sponsors to consider and determine whether their welfare benefit plans are subject to those requirements (and if so, to ensure compliance therewith). Many different types of employee benefit plans and programs fall under ERISA's definition of "welfare benefit plan", which includes medical, surgical, and hospital benefits (e.g., medical, dental, and vision plans, health flexible spending accounts, health reimbursement accounts, employee assistance plans); benefits in the event of sickness, accident, disability, death, or unemployment (e.g., disability, life, AD&D, severance plans); vacation benefits; apprenticeship or other training programs; scholarship funds; and prepaid legal services. Despite failing under this definition, many welfare benefit plans are nevertheless exempt from ERISA's compliance requirements if they satisfy a specific exemption, including most notably, the "voluntary plan safe harbor." This month's Compliance Corner focuses on voluntary plans and explains how employer plan sponsors can offer certain supplemental benefit plans or programs under the voluntary plan safe harbor exemption in order to avoid ERISA's various compliance requirements.

What are Voluntary Benefits?

Generally, voluntary benefits are not part of the employer's standard benefits package that includes health and dental insurance, for example. Instead, voluntary benefits are optional for the employer (as in, there is no law or possible tax penalty if the employer does not offer these benefits) and employee and are offered to employees in order to supplement the employer's other benefit offerings. Generally, through voluntary benefit plans or programs, the employer will permit its employees to purchase voluntary insurance policies that provide coverage to employees individually. This includes, for example: (i) life insurance policies; (ii) disability coverage; (iii) accident and sickness programs (e.g., critical illness, hospital indemnity), and (v) other specialty policies (e.g., pet insurance)

Voluntary benefits are intended to attract and retain talent and address employees' overall health and wellness, including financial and personal wellness, without adding significant costs to the employer. Generally, employers and employees share the cost of these benefits, but more often than not, employees pay for the full cost of the premiums and any employer costs are limited to possible administrative fees or ancillary costs related to informing employees about the benefits available.

While voluntary benefit programs come with many advantages, some employers are hesitant to offer these types of supplemental benefits in addition to those standard benefits that may be more necessary in the current job market. In addition to potential costs, some employers shy away from the additional legal compliance requirements that come with employee benefits generally. For some employers, the voluntary benefit exemption from ERISA may provide relief in this respect.

Voluntary Plan Safe Harbor Exemption

As mentioned above, ERISA exempts certain benefit plans and programs from its coverage pursuant to various exemptions, one of which is the voluntary plan safe harbor exemption. Notably, however, not all voluntary benefits generally discussed above will satisfy the voluntary benefit safe harbor exemption. As set forth below, there are specific conditions that must be satisfied to utilize this safe harbor, and such conditions go beyond the common misconception that such benefits must only be "voluntary" in the sense that they are optional and fully paid by the employee.

A plan or program can utilize the voluntary plan safe harbor if it satisfies the following four (4) conditions: (i) no contributions are made by an employer; (ii) participation in the program is completely voluntary for employees; (iii) the employer receives no consideration (cash or otherwise) regarding the program (subject to limited exceptions); and (iv) the employer engages in limited and specific functions and does not endorse the program. See 29 C.F.R. § 2510.3-1(j). Each of these conditions,

which are discussed in more detail below, must be satisfied to utilize the voluntary plan safe harbor.

No Employer Contributions

The voluntary plan safe harbor is unavailable if the employer makes any contribution for the benefits or coverage at issue. Said another way, the benefit must be paid exclusively by the employee, and the employer cannot pay any portion of the premium.

Federal courts have found an employer will not be deemed to make contributions in this respect if the employer is merely acting as a conduit for the payment of premiums (i.e., the employer makes payroll deductions and remits the deductions to the insurer). Notably, however, IRS guidance indicates that in order to satisfy this safe harbor condition, any such payroll deductions must be made on an after-tax basis. More specifically, IRS guidance treats pre-tax payroll deductions made through an Internal Revenue Code Section 125 cafeteria plan to be "employer contributions". As such, if an employer permitted employees to pay for any voluntary benefit coverage through the employer's cafeteria plan on a pre-tax basis, such payment would likely amount to an "employer contribution" and fail to satisfy the first element of the voluntary plan safe harbor.

Several federal courts have addressed other specific scenarios that are illustrative in determining whether the voluntary benefits were paid exclusively by employees, and such courts have taken different approaches in this respect. For example, a federal district court rejected the argument that an employee's receipt of a discounted rate for an individual disability policy was an "employer contribution" as the employer was not responsible for, or involved in, obtaining the discount for the employee, which was offered because the employee agreed to a specifically billing arrangement. See Shrago v. Unum Life Ins. Co. of Am., No. 8:20-CV-01097-PX, 2021 WL 3188320, at *6 (D. Md. July 28, 2021). Alternatively, another federal court found that where the employer facilitates and negotiates a discounted rate on behalf of its employees with respect to a voluntary benefit, the employer's involvement amounted to an "employer contribution" preventing the application of the voluntary plan safe harbor. See Bommarito v. Nw. Mut. Life Ins. Co., 2018 WL 3537118 (E.D. Cal. July 23, 2018.

Voluntary Participation

In order to utilize the voluntary plan safe harbor to be exempt from ERISA, the voluntary plan must be completely involuntary for employees. If there is any indirect or direct requirement that employees participate in the plan or program, it will be deemed to be involuntary. For example, if an employer automatically enrolls employees in the coverage or plan offered, it will be considered involuntary.

Employer Receives No Consideration

The voluntary plan safe harbor is unavailable if the employer receives any consideration (cash or otherwise) from the insurance carrier for offering a voluntary benefit or plan to its employees.

No Employer Endorsement

In order to utilize the voluntary plan safe harbor, the employer cannot endorse, and must have a limited role related to, the voluntary benefits. Essentially, there must be a certain level of separation between the employer and the benefits; however, the specific level of separation required is not entirely clear. As a result, this is the most difficult condition to satisfy and often is the reason employers cannot rely on the voluntary plan safe harbor to avoid ERISA coverage.

The regulations provide a brief list of the permitted functions the employer can do with respect to the voluntary benefits, which include: (i) permitting the insurer to publicize the program to the employer's employees; (ii) collecting premiums through payroll deductions; and (iii) remitting premiums to the insurer. Applicable guidance further provides that employer may facilitate the publicizing and marketing of the program. Federal courts have considered the question of what is an appropriate level of employer involvement on several occasions. Engaging in administrative activities that are incidental to such plans or program, in a neutral way, like designating a policy's effective date, issuing certificates to enrolled employees, and maintaining a list of enrolled employees, is generally permitted under the applicable guidance.

While performing these limited functions, however, employers cannot "endorse" the plan or program in a way that encourages or pushes employees to participate in the plan. This determination is factual and will depend on the facts and circumstances of each particular situation. Courts have concluded that "endorsement" includes urging or encouraging employees to participate in the program; expressing positive judgment regarding the program; or otherwise doing or saying anything that would cause an employee to reasonably conclude that the program is established, maintained, or backed by the employer.

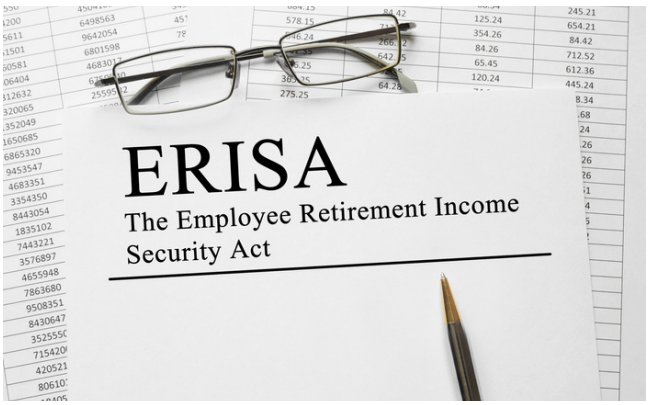
For example, courts have found there to be potentially sufficient levels of employer "endorsement" in the following activities (usually, in some combination thereof): (i) assisting individuals with claims, maintaining claims forms, or facilitating appeals; (ii) promoting the plan or program to employees as part of the employer's customary benefits package and endorsing it in its benefits guide or similar communication; (iii) making the plan available to employees on a pre-tax basis through the employer's cafeteria plan; (iv) determining eligibility for the plan or program; (v) making suggestions to the insurer regarding plan design and structure; (vi) setting key terms, including amount of coverage, for the plan; (vii) acting as a plan administrator by engaging in activities like establishing minimum benefit levels and maximum monthly payments; (viii) linking coverage to continued employment; and (ix) being the named policy holder or entering into a contract with the insurer. Moreover, if the employer provides employees with plan documents that refer to the plan or program being "subject to ERISA," the

the employee's "rights under ERISA," or the benefit being an "employer plan", courts may be more likely to conclude that there is endorsement and the safe harbor is unavailable. Notably, courts often rely on a combination of factors to conclude that an employer has endorsed a voluntary plan. As a result, it is not clear what, if any, one factor may be most determinative here; however, the more of these types of activities an employer engages in, the more likely it is that a court or the DOL will find that the employer is endorsing the plan (and cannot utilize the voluntary plan safe harbor).

For simplicity, some courts apply a five-part test to determine whether an employer has endorsed a voluntary plan, which provides a good roadmap for employers trying to make this determination. This test considers the following factors: (i) whether the employer has played an active role in determining which employees are eligible for coverage or negotiating the terms of the policy or benefits thereunder; (ii) whether the employer is named as the plan administrator; (iii) whether the employer has provided an summary plan description or other communication that specifically refers to ERISA or indicates that the plan is subject to ERISA; (iv) whether the employer has furnished any materials to its employees indicating that it has endorsed the plan; and (v) whether the employer participates in claims processing for the plan.

Conclusion & Next Steps

As detailed above, employers relying on the voluntary plan safe harbor exemption must ensure they are refraining from engaging in any activities that could amount to potential "endorsement" of the plan and jeopardize their exemption status. This will require coordination and communication among an employer's personnel responsible for benefit plan administration. For employers who have ample experience with ERISA compliance, avoiding ERISA through the voluntary plan safe harbor may not be worth the time and effort required to ensure the exemption applies appropriately; however, there are significant advantages to being exempt from ERISA, including the ability to avoid certain compliance requirements. If you are interested in implementing a voluntary benefit plan and/or need assistance in ensuring any such plan satisfies the voluntary plan safe harbor exemption, you should reach out to your benefits consultants or counsel.



STAY IN THE KNOW...

- The IRS, Department of the Treasury, EBSA, Department of Labor, and Centers for Medicare & Medicaid Services, and Department of Health and Human Services have announced an extension of the comment period for the proposed rules on requirements related to the Mental Health Parity and Addiction Equity Act. The extension, granted due to considerable interest by commenters, is an additional 15 days, from October 2, 2023 to October 17, 2023.

- The 2024 maximum annual limitation on cost sharing for self-only coverage under a covered group health plan is $9,450 (and $18,900 for other coverage). This is a 3.8 percent increase from 2023 limits ($9,100 for self-only coverage and $18,200 for other coverage).

- The U.S. Equal Employment Opportunity Commission ("EEOC") recently released is Strategic Enforcement Plan for 2024 to 2028. Of its six subject matter priorities for the next four years, among them (1) eliminating barriers in recruitment and hiring, (2) protecting vulnerable workers, (3) addressing selected emerging and developing issues, (4) advancing equal pay, (5) preserving access to the legal system, and (6) preventing and remedying systemic harassment, two of those subject matter priorities seek to address the role of "technology - related employment discrimination" and "the use of technology, including artificial intelligence and machine learning, to target job advertisements, recruit applicants, or make or assist in hiring decisions."

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